

IRO REVIEWER REPORT - WC



Claims Eval

Notice of Independent Review Decision

April 17, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Hardening Daily x 2 weeks (10 sessions)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

American Board of Preventive Medicine

Certified in Occupational Medicine

Certified in Aerospace Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

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PATIENT CLINICAL HISTORY [SUMMARY]:

xx-xx-xx Unknown Provider, the claimant states that a piece of metal weighing 50 pounds fell on his left foot. He stated that the pain when he walks is 10/10. X-ray of the left foot showed a metatarsal diaphyseal fracture. Diagnosis: Left foot fracture-contusion. Plan: Tetanus, Tdap, crutches, air boot, ice pack, naproxen 500 mg

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dispensed 431 tab p.o. bid., and Tramadol 50 mg 1 tab p.o. t.i.d. There is an orthopedic surgery STAT referral. There was communication with concerning this claimant's medical status. Claimant was placed on modified activity. He must use crutches 100% of the time while walking. He was scheduled with physical therapy for gait training with crutches for 1 visit. The claimant will have orthopedic surgery STAT referral.

xx-xx-xx the claimant states that earlier today, the claimant was working, he had a piece of metal that was large went on his left foot sustaining a left foot crush injury. He was seen earlier today. was to contact. Over the day, the pain has gotten worse. He was only given tramadol and naproxen. He has not been elevating the injury. Assessment: Left foot 2nd metatarsal fracture with a significant soft tissue injury with some dorsal swelling and an abrasion on the dorsum of the foot. Plan: The evaluator is going to recommend getting some antibiotics for that abrasion as he is a diabetic. The evaluator will give him Keflex 500 mg every 6 hours. The evaluator is also going to recommend narcotics. The evaluator is going to keep him off work. The evaluator recommends strict elevation in a boot. The evaluator will go ahead and see him back next Tuesday for a repeat evaluation and wound check, the evaluator told him if his pain gets worse with narcotics or swelling gets way too severe then to go straight to the emergency room or to call the office.

4-17-12 the claimant comes in today for a date of injury of xx-xx-xx when he had a crush injury to his left foot sustaining a 2nd metatarsal fracture. He also has a small abrasion on the dorsum of the foot. The evaluator gave him some antibiotics. The swelling and pain have gotten significantly better. He still using a boot He still has 7/10 pain. He is taking hydrocodone and Keflex. He has not been working. On physical exam, the swelling is much better. There is no warmth. No erythema. He still has significant swelling on the dorsum of his foot and some bruising that goes all the way down the lateral aspect of the hind-foot which suggests that he has been staying off it and being compliant with elevation. His neurovascular exam is normal. There is good capillary refill and mild hypersensitivity over the dorsum of the foot. He is able to wiggle his toes. He is able to move his ankle without difficulty. Assessment: Crush injury of the left foot with severe soft tissue injury and swelling. He does have a 2nd metatarsal fracture. The evaluator does not think that the fracture was opened but he did have an abrasion on the dorsum of his foot and was treating this with antibiotics prophylactically given the fact that he is a diabetic. He will go ahead and continue a 10-day course of Keflex and continue hydrocodone for the pain. The evaluator is going to have him be non-weight-bearing and strict elevation. The evaluator will see him back in 2 weeks for a repeat evaluation.

5-1-12 the claimant follows up today for fracture of the 2nd metatarsal. The swelling has decreased. He is still having significant pain. He had finished Keflex and he is taking Vicodin for pain. He is not currently working. Assessment: Crush injury to the left foot with a 2nd metatarsal fracture. He had severe swelling and now he

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is having some nerve-related symptoms that may be early reflex sympathetic dystrophy secondary to crush injury. Plan: The evaluator is going to go ahead and recommend Lyrica as well as some Norco for pain. The evaluator is going to keep him non-weight-bearing and allow him to go back to light duty, the evaluator is going to start some physical therapy mainly for the reflex sympathetic dystrophy symptoms to try to promote some early range of motion of the ankle and toes as well as to do some whirlpool therapy and some edema control modalities.

6-8-12 CT of the left foot showed there is an oblique, coronal fracture through the dorsum of the distal shaft of the left foot second metatarsal bone. There may also be a second nondisplaced cortical fracture through the medial cortex of the articular distal second metatarsal bone. There is a nondisplaced sagittal 1 cm of fracture through the dorsal cortex of the midshaft third metatarsal bone.

6-19-12 the claimant sustained a crush injury to his left foot. He states he is about the same. He has a constant burning and throbbing pain in the middle of his foot. The swelling has improved. There is some discoloration that he states about the left foot. He denies any temperature changes. He has been working light duty. He has been wearing a boot and has been using crutches. Assessment/Plan: Crush injury, left foot, with multiple metatarsal fractures a nondisplaced 3rd metatarsal fracture seen only on the CT scan and a 2nd metatarsal shaft fracture. There is some indurated scar tissue from the swelling. It is likely causing neuritis and possibly some early reflex sympathetic dystrophy, which the evaluator thinks is possibly the etiology of some of his pain that is failing to improve. He also has diabetes and may have a component of diabetic neuropathy that is complicating the issue. At last visit, there was minimal callus seen. Given his diabetes, he certainly is at high risk for a nonunion. The evaluator is going to go ahead and see him back in 3 weeks. If there is no callus formation seen at this time, the evaluator may consider recommending an Exogen bone stimulator to help improve healing of the fracture. The evaluator is also going to start him on some Neurontin for an antineuritic-type pain. He will continue the Norco and the tramadol. He will stay on light duty and the evaluator is also going to recommend some physical therapy for some modalities and early range of motion with the possibility of RSD complicating this injury.

9-24-12 preoperative and postoperative diagnosis: Left second metatarsal shaft nonunion. Procedure: Left second metatarsal shaft fracture nonunion takedown with open reduction and internal fixation using calcaneal autograft.

1-30-13 the claimant is status post a left second metatarsal shaft nonunion takedown with ORIF on 9-24-12. At his last visit, the evaluator recommended a CT scan to evaluate the metatarsal fracture healing, apparently this study was approved, but he has not gone for the study yet. He continues to complain of some pain around the forefoot region with ambulation. Impression: Closed fracture of metatarsal bone, left, 3rd, closed fracture of metatarsal bone, delayed union, left, 2nd, crushing injury, foot, left. Plan: The claimant was prescribed Ultram.

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2-1-13 CT of the left foot showed a plate and screws is present on the 2nd metatarsal. The fracture is healed.

2-8-13 the claimant is status post a left second metatarsal shaft nonunion takedown with ORIF on 9-24-12. He recently went for a CT scan to evaluate fracture healing. The continues to have some pain in the foot He has been working with restrictions. Impression/Plan: Missing pages.

2-13-13 the claimant recently completed an initial evaluation. The evaluation included the completion of psychological screening questionnaires. This preliminary screening is used to determine the need for psychological services to assist him in coping with pain and/or injury related stress within a multidisciplinary approach to occupational rehabilitation. These results and summary provide information about current status and do not provide any mental health diagnosis. The claimant indicated that he is experiencing a severe level of pain (4/10) with his current diagnosis (825.5) on the National Institute of Health Pain Consortium Numeric Pain Rating Scale (McCaffery and Beebe, 1993). Plan: It is recommended that be treated in a work hardening program with a comprehensive multi-disciplinary treatment team approach. The reported current level of functioning, personal and familial impact, reported symptoms of mild psychosocial stress, inadequate coping mechanisms, significant fear avoidance beliefs and behaviors, and reduced quality of life makes him an inappropriate candidate for a work conditioning program which would be inadequate for his current needs.

2-13-13 Functional Capacity Evaluation shows the claimant is functioning at a Light-Medium PDL.

2-20-13 Requested Work Hardening daily x2 weeks (10 sessions).
Recommendation: Adverse determination.

3-8-13 the claimant is status post a left second metatarsal shaft nonunion takedown with ORIF on 9-24-12. At his last visit, they recommended work conditioning. Apparently, he went for an evaluation but has not had any other therapy. He continues to take as Ultram for pain. He is using an orthotic. He still has significant pain in the foot with weight-bearing. He has been off of work due to restrictions. Impression: Closed fracture of metatarsal bone, left, 3rd, closed fracture of metatarsal bone, delayed union, left, 2nd, crushing injury, foot, left. Plan: went over the findings at length with the claimant with use of an interpreter. He may be having some pain from his implants at the second metatarsal. The evaluator did talk about possible implant removal in the future. The evaluator would first like to again try some work conditioning. He will continue with his pain medication and orthotics. He will also continue with work restrictions. Follow-up for work conditioning. The claimant is medically clear to return to work on a light-modified duty status. Note

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was provided. Take Ultram as needed for pain control. Follow-up after work conditioning.

3-19-13 this letter is being written for reconsideration of the denial for the Work Hardening Program. sustained a work-related injury on xx/xx/xx. Diagnostic testing revealed a 2" metatarsal shaft fracture. He underwent a surgical repair (ORIF) in September of 2012. was treated for six weeks and then participated in 22 sessions of physical therapy. completed a Functional Capacity Evaluation on 2-13-13. The FCE revealed several deficits that are preventing his return to work. The deficits include left foot pain, decreased left ankle and forefoot range of motion, decreased left lower extremity strength, decreased ability to lift/carry (unable to meet the required physical demand characteristic level), decreased ability to bend/squat, decreased ability to push/pull, decreased tolerance to prolonged standing/walking, decreased ability to negotiate stairs/ladders and poor cardiovascular endurance. A written job description confirmed that has to perform prolonged standing/walking, bending, squatting, pushing/pulling, climbing, kneeling/crawling, reaching, grasping, operating machinery and lifting/carrying up to 50 pounds. At this time he cannot safely or efficiently perform all of these job duties. He can currently lift and carry 35 pounds. During the evaluation, reported the he must lift and carry 75 pounds; however, the written job description states that the requirement is 50 pounds. Either way, the claimant is unable to perform at the required physical demand characteristic level. It is recommended that participate in a daily 8-hour Work Hardening Program for two weeks. A comprehensive Work Hardening Program would provide a plan of care to include multiple work-simulation activities. The repetitive performance of his required job tasks will help to facilitate a safe and timely return to work at full duty without restrictions.

3-20-13 performed a Medical Review. It was his opinion based on the clinical information provided, the appeal request for work hardening daily x 2 weeks (10 sessions) is not recommended as medically necessary. The initial request was non-certified noting that current functional issues appear to be limited to foot pain after a MT fracture ORIF. This is not something that is reasonably amenable to a work hardening program. The claimant's functional issues appear to be limited by foot pain as opposed to some tangible or documented loss of function of the foot that is amenable to any tertiary rehabilitation program. Foot pain with weight-bearing is not amenable to work hardening since it is not some loss of intrinsic foot function. Letter of reconsideration dated 3-19-13 indicates that the functional capacity evaluation revealed several deficits that are preventing his return to work. There is insufficient information to support a change in determination, and the previous non-certification is upheld. Peer to peer discussion was unsuccessful.

Physical performance requirements.

4-3-13 Request for IRO in view of denial of Work Hardening.

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ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the medical records provided, work hardening is not supported. The records attest that the claimant had a surgical procedure for non union with ORIF on 9-24-12. In the records since, there is no mention of post operative therapy. Then in February 2013, there was a psychological evaluation, which noted the claimant had severe pain, and certain traits, but no actual DSM pathology. Still, the doctorate level counselor recommended work hardening as it was felt he was an inappropriate candidate for work conditioning. confirms on 3-8-13 that the claimant has had no other therapy. In the denial on 3-20-13, which was an appeal on the work hardening, notes that the functional limitations are limited to the foot region, and a comprehensive multidisciplinary program would be unnecessary. In the ODG criteria, the case fails a prime element of the criteria for admission to a Work Hardening (WH) Program: "Previous PT: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches." There is no such evidence that the claimant exhausted active therapy followed by plateau. Moreover, although there are psychological traits mentioned by the psychologist, there is no DSM level psychopathology that might warrant a full multidisciplinary program. Therefore, the request for Work Hardening Daily x 2 weeks (10 sessions) is not reasonable or medically necessary.

Per ODG 2013 Criteria for admission to a Work Hardening (WH) Program:

(1) Prescription: The program has been recommended by a physician or nurse case manager, and a prescription has been provided.

(2) Screening Documentation: Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing

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should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.

(3) Job demands: A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).

(4) Functional capacity evaluations (FCEs): A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.

(5) Previous PT: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.

(6) Rule out surgery: The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).

(7) Healing: Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.

(8) Other contraindications: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.

(9) RTW plan: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.

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(10) Drug problems: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.

(11) Program documentation: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should be documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.

(12) Further mental health evaluation: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.

(13) Supervision: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.

(14) Trial: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.

(15) Concurrently working: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.

(16) Conferences: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.

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(17) Voc rehab: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.

(18) Post-injury cap: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs).

(19) Program timelines: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.

(20) Discharge documentation: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.

(21) Repetition: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

ODG Work Conditioning (WC) Physical Therapy Guidelines

WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal

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barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.

Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**