

**MAXIMUS Federal Services, Inc.**  
**4000 IH 35 South, (8th Floor) 850Q**  
**Austin, TX 78704**  
**Tel: 512-800-3515 ♦ Fax: 1-877-380-6702**

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**Notice of Independent Review Decision**

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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** June 4, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Work hardening program x 10 sessions at 5 times a week for 2 weeks at 8 hours a day.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

**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)

I have determined that the requested work hardening program x 10 sessions at 5 times a week for 2 weeks at 8 hours a day is not medically necessary for treatment of the patient's medical condition.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 5/1/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 5/14/13.
3. Notice of Assignment of Independent Review Organization dated 5/15/13.
4. Denial documentation dated 3/27/13 and 4/29/13.
5. Letter of Reconsideration from DPT dated 4/12/13.
6. Functional Capacity Evaluation dated 3/22/13.
7. Operative Report dated 11/29/12.
8. Clinic notes from MD dated 2/6/13, 2/12/13, 3/12/13 and 4/26/13.
9. Work Hardening/Work Conditioning Program – Prescreen Evaluation and Recommendations dated 3/21/13.
10. Pre-certification requests dated 3/22/13 and 4/12/13.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work related injury on xx/xx/xx injuring her left knee. On 11/29/12, the patient underwent left knee arthroscopic partial medial and lateral meniscectomies, left knee partial synovectomy in multiple compartments, left knee arthroscopic removal of loose body, and left knee arthroscopic chondroplasty of the medial femoral chondral injury. The patient's preoperative diagnoses were left knee medial meniscus, left knee lateral meniscus tear, and left knee synovitis. On 2/6/13, the patient rated her pain level at 5/10 and was not taking any pain medications. On the same date the patient had flexion to 125 degrees and lacked 5 degrees of full active extension and ambulated with a fairly normal gait. The patient was given Celebrex and was medically cleared to return to work on a light to modified duty status and was to continue physical therapy as instructed. On 3/12/13, she continued to report pain to the anterior and posterior aspect of her knee and had been taking Celebrex and working within her restrictions. An exam revealed no obvious effusion and no specific areas of point tenderness. The patient did have some quadriceps atrophy and lacked a few degrees of full extension and flexed to 135 degrees. On 3/21/13, she was recommended for work hardening and it was noted she would be monitored throughout the program to determine if additional psychological services may be required, including evaluation for chronic pain management due to somatic and emotional symptoms and pain-focused behaviors. On 3/22/13, the patient underwent a functional capacity evaluation and was recommended for an 8 hour per day work hardening program for 4 weeks to address physical deficits. On 4/26/13, the patient's examination revealed that she had a fairly normal gait and had quadriceps and hamstring atrophy. The patient had no obvious effusion, and she could fully extend the knee with flexion to 120 degrees. It was noted that she was medically cleared to return to work on a light to modified duty status and she was continued on Celebrex.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's initial denial stated that there was no documentation that a specific, defined return to work goal or job plan had been established, communicated, or documented between the employer and employee. In addition, the denial stated that there were no physical therapy notes provided to document the patient had improvement followed by a plateau. On 4/29/13, the URA reported that the request was again non-certified. According to the URA, the physical examination findings and objective documentation provided in the records does not support documentation of the associated response to therapy including initial improvement with follow up documentation of plateauing and without full documentation or evaluation from the treating provider delineating specific defined return-to-work goals, communication or documentation between the employer and employee, the request therapy would not be supported. In addition, the denial stated that there were no physical therapy notes provided for review documenting the response to therapy including initial evaluation or response to treatment.

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

In this patient's case, the Official Disability Guidelines (ODG) does not support the requested work hardening program. The records provided did not include physical therapy notes to document improvement or plateau. Although the patient has been instructed she can return to work on a light to modified duty status there was no official documentation between the employer and the employee to document work status. In addition, there was no documentation of other behavioral comorbidities or other conditions preventing this patient from returning to work. As such, the requested work hardening program is not considered medically necessary.

Therefore, I have determined the requested work hardening program x 10 sessions at 5 times a week for 2 weeks at 8 hours a day is not medically necessary for treatment of the patient's medical condition.

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**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 JUDGMENT, 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)**