

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

Notice of Independent Review Decision

DATE OF REVIEW: October 29, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional Work Hardening Program x 10 Sessions Left Foot/Ankle (CPT 97545/97546).

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

M.D., Board Certified in Occupational 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)

I have determined that the requested additional work hardening program x 10 sessions left foot/ankle (CPT 97545/97546) are 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 10/8/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/8/13.
3. Notice of Assignment of Independent Review Organization dated 10/9/13.
4. Denial documentation dated 8/26/13 and 10/3/13.
5. Pre authorization request dated 9/25/13.
6. Letter for reconsideration dated 9/24/13.
7. Request for continuation in work-hardening program dated 8/20/13.

8. Clinic notes dated 8/20/13 and 9/2/13.
9. Functional Capacity Evaluation dated 8/19/13.
10. Progress report dated 3/27/13.
11. Radiology report dated 4/11/12, 4/24/12, 4/26/12, 8/9/12 and 1/8/13.
12. Operative report dated 4/16/12.
13. Psychosocial evaluation dated 4/23/13.
14. Updated psychosocial evaluation and amended request for services dated 9/2/13.
15. Clinic notes dated 4/11/12 and 4/26/12.
16. Clinic notes dated 1/8/13, 4/13/13, 4/16/13, 6/20/13 and 6/30/13.
17. Clinic notes dated 6/9/12, 8/9/12 and 11/27/12.
18. Chronic Pain Management Program Initial Physical Performance Report dated 8/20/13.
19. Patient weekly progress reports dated 5/10/13, 5/17/13, 5/24/13, 7/19/13, 7/26/13, 8/2/13, 8/8/13 and 8/15/13.
20. Designated Doctor Examination dated 2/8/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with chronic ankle pain associated with a work-related injury on xx/xx/xx. On 4/16/12 the patient had open reduction and internal fixation of the fracture left calcaneus performed and has a diagnosis of complex comminuted fracture of the left calcaneus. The record indicates that the patient has had an extensive period of time off of work. The medical records submitted for review indicate that the patient has been treated with analgesic medications. A psychosocial evaluation dated 4/23/13 indicates that the patient has developed comorbid psychiatric issues with a diagnosis of anxiety disorder due to a general medical condition with panic attacks. A functional capacity evaluation (FCE) dated 8/19/13, indicates that the patient works as a construction laborer which requires heavy physical demand level and that the patient be weight-bearing a majority of his work time. The FCE revealed that the patient tested within the medium-to-heavy physical demand level. A progress note dated 8/20/13 indicates that the patient reports persistent pain at 8/10, limps with the left leg and that he is not working. The patient reports that the work hardening program is helping and that he is taking ibuprofen for pain relief. The provider noted that the patient's left ankle range of motion was abnormal, tenderness to palpation and that the patient exhibits localized edema. The patient was given a refill of tramadol for pain relief. A letter from the patient's provider dated 9/24/13 indicates that the patient has had 10 sessions of work hardening.

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) support the requested additional work hardening program. According to ODG guidelines, a work hardening program should not exceed 20 full days over four weeks. In this case, the patient has had half the requisite treatment or 10 days. ODG guidelines further state that trial treatment is not supported for longer than one to two weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. In this case, the patient has made appropriate strides to date and he reports decreased pain with his objective abilities improving. The record indicates that the patient is testing within the medium to heavy

physical demand level and that he does have a clear return to work plan as a construction worker/laborer. This patient has an arduous occupation, which requires additional rehabilitation above and beyond that previously obtained through conventional physical therapy. Thus, the criteria set forth in the ODG guidelines have been met as the records submitted for review indicate a specific need for additional work hardening. Given the patient's return to work plan, the medical necessity for a work-specific multidiscipline program has been established. As such, the requested additional work hardening program at the frequency of 10 sessions is medically necessary.

In conclusion, I have determined the requested additional work hardening program x 10 sessions left foot/ankle (CPT 97545/97546) is medically necessary for treatment of the patient's medical condition.

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)