CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: April 4, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Work Hardening Program 80 Hours 5xWkx2 Wks Right Knee

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in Physical Medicine and Rehabilitation with over 18 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He was taken to Hospital where the claimant reports he was examined, medicated and x-rayed. He was informed he had a fracture of the right knee. He was reportedly seen by and orthopedic surgeon, who advised he would benefit from a course of therapy, but the therapy program at that time was never started.

On March 21, 2013, MRI Right Knee, Impression: 1. Areas of bone edema are present within the medial femoral condyle, medial tibial plateau, and fibular head consistent with areas of bone contusion and microtrabecular fracture. 2. Intact cruciate and collateral ligaments of the knee. 3. Intact menisci. 4. Knee effusion.

On May 22, 2013, the claimant was re-evaluated for continued right knee discomfort he reported as constant and sharp in nature, and aggravated with physical activities. On evaluation the claimant had an altered gait cycle and was wearing a knee brace on the right knee. There was reduced ROM as compared to the left. There was discomfort with active ROM. There was reduced strength of the right knee compared to the left. There was discomfort at the anterior, lateral and medial aspects. Plan: Prescribe Hydrocodone 5/500mg and Motrin 800 mg. Follow up Physical Therapy pending approval.

From June 4, 2013 through July 2, 2013, Physical Activities Logs document 15 minutes on the Stationary Bike, 10 minutes with the Thera Ball and 10 minutes with the Thera/Band/Tube/Putty. Weights: At the start for Hip/Knee: 0 lbs for 3 sets of 8 reps. Leg Extensions: 0 lbs for 3 sets of 8 reps. Last recorded on June 28, 2013 as Hip/Knee: 5 lbs for 3 sets of 8 reps and Leg Extensions: 5 lbs for 3 sets of 8 reps. On June also had 2 units of Balancing/Wobble Boards and 5 minutes of Quad Exercises.

On July 18, 2013, the claimant presented with popping, clicking, locking and giving out of the right knee. On examination there was trace effusion, diffuse soft tissue swelling. With palpation there was tenderness of the medial joint line and lateral joint line. Positive McMurray. ROM was limited due to pain. Assessment: Sprain of the right knee. Plan: Continue physical therapy. Injected knee with 10cc lido/cortisone; consider scope if no better.

On August 1, 2013, the claimant presented with no improvement from the injection. Pain was reported as much as 10/10. Plan: Pt has tried and failed conservative treatment consisting of PT and cortisone injection, recommend diagnostic arthroscopy.

On August 27, 2013, Operative Report. Postoperative Diagnosis: Partially torn medial and lateral meniscus, complete 3-compartment synovitis and adhesions. Procedure Performed: Right knee diagnostic arthroscopy with partial medial lateral meniscectomy, complete synovectomy and removal of adhesions.

On November 1, 2013, the claimant presented for PPE/ROM. It was reported the claimant had completed one round of post-operative therapy and had a positive response. Rom of the right knee as of 7/26/13: Flexion 95 degrees and Extension -10 degrees. ROM of the right knee as of 11/01/13: Flexion 121 degrees (21% improvement) and Extension -4 degrees (100% improvement). Muscle Strength: Left knee flexors: 69 lbs, Right knee flexors: 19 lbs. Left knee extensors: 72 lbs, Right knee extensors: 21 lbs. Girth Measurements: (6 inches above the patella) Right 41 cm and Left 45 cm. (6 inches below the patella) Right 36 cm, Left 37 cm.

On November 4, 2013, the claimant presented to a Designated Doctor Evaluation. opined the claimant had reached MMI on 11/4/2013 with a 0% impairment for the accepted conditions of right knee contusion and right knee internal derangement.

Disputed conditions were listed as right medial and lateral meniscus tears for which had also reached MMI as of 11/4/2013 with a 4% impairment rating.

On November 25, 2013, the claimant presented for a Functional Capacity Examination with OTR. Claimant stated returning to that job was not possible, no light duty is available. His vocational goal is to return to gainful employment. Subjective: Current complaints of recurrent pain at right knee, increased with activity. Increase in pain is caused by daily functional bending movements, standing and walking. Relief achieved with rest. Currently taking pain medications PRN. Assessments: Results of the FCE revealed the claimant was functioning at the light work level. He was able to dynamically lift 15 pounds infrequently from floor to knuckle. Endurance testing was graded as good. Pace during testing was described as moderate. Body mechanic were considered good. The claimant exhibited pain behaviors during testing procedures requiring squats. Recommendations: Candidate for a multi-disciplinary return to work program to improve strength, endurance, and tolerance to work related activities.

On November 26, 2013, the claimant present for an Initial Behavioral Medical Evaluation with LMSW. Current Medications: None noted. Current Injury-Related Variables Contributing to Symptomology: Symptoms of sleep disturbance along with symptoms of depression and anxiety. These were not present before his injury. Test Results: On BDI II, he scored 20, which is in the Moderate category. On the BAI he scored a 17, also in the Moderate category. Diagnostic Impression: Axis I: Anxiety Disorder (Moderate) due to a general medical condition. Depressive Disorder (Moderate) due to a general medical condition. Sleep Disorder due to a general medical condition. Axis II: No diagnosis. Axis III: Unresolved work injury sustained 2-22-13. Axis IV: Moderate to severe Medical, Social, Occupational, and Economic Problems. Axis V: Current GAF 55; highest in the past year 72. Treatment Recommendations: The claimant would benefit from a work-hardening program to address both physical and psychological issues, enabling him to return to work.

On December 3, 2013, submitted a Pre-Authorization Request for 80 Hours of Work Hardening. Sort Term Goals: 1. Increase Strength, Stamina, Endurance and overall Function within the first 2 weeks. 2. Increase PDL from light to medium within the first two weeks. 3. Reduce overall discomfort. Long Term Goals: 1. Increase Strength, Stamina, Endurance and overall Function to pre-injury status. 2. Increase PDL to heavy. 3. Return to regular duty w/o restrictions. Behavioral Goals: Short Term: 1. Reduce anxiety to the mild range within the first two weeks. 2. Reduce depression to a mild range within the first two weeks. 3. Increase GAF by 5-10%. Long Term: 1. Reduce Emotional Problems to a functioning level. 2. Return back to regular duty w/o restrictions. 3. Release as a functioning member of society.

On December 5, 2013, the claimant presented for follow up after 6 sessions of physical therapy. Pain was rated 4/10. On evaluation of the right knee, there was positive quad atrophy, trace effusion, diffuse soft tissue swelling and medial tenderness present. Assessment: 1. Tear of medial cartilage or meniscus of

knee. 2. Sprain of knee. Plan: Claimant is improving, still lacks strength and some range of motion. Recommending continue with post op physical therapy followed with work hardening.

On December 6, 2013, UR. Rationale for Denial: The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. Current medications are not provided. Diagnostic studies are not provided. Other therapies include postoperative physical therapy. A Preauthorization Request was submitted on 12/03/13 for 80 hours of work hardening. Prior to the request, the patient underwent a Functional Capacity Evaluation on 11/25/13. It was determined that the patient was functioning at a light work level, and was unable to perform the demands of his previous job which required heavy work level. The patient was referred after a Behavioral Medicine Evaluation on 11/26/13 for a work hardening program to address physical and psychological issues. Current diagnoses include status post right knee synovectomy, status post arthroscopy with partial medial and lateral meniscectomy of the right knee, status post removal of adhesions, anxiety disorder, depressive disorder, and sleep disorder. Official disability Guidelines state criteria for admission to a work hardening program includes specific screening documentation. There should be documentation of work related musculoskeletal deficit that has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude the ability to safely achieve current job demands. There should be evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by a plateau, with evidence of no likely benefit from continuation of this previous treatment. As per the clinical notes submitted, the patient underwent a medical evaluation on 11/04/13. Upon review of complete medical records and a physical examination, the patient was placed at maximum medical improvement on that date with a 4 percent whole person impairment rating. The patient demonstrated normal range of motion, normal strength, no tenderness, crepitation, swelling or joint subluxation, normal reflexes, and no motor or sensory deficits. There was no documentation submitted that provided evidence of an adequate trial of active physical rehabilitation with improvement followed by a plateau, with evidence of no likely benefit from continuation. Based on the clinical information received and the Official Disability Guidelines, the request is non-certified.

On January 2, 2014, UR. Rational for Denial: Previous non-certification was given because there was no evidence of an adequate trial of active physical rehabilitation with improvement followed by a plateau, with evidence of no likely benefit from continuation of treatment. Updated records include a 12/19/13 appeal letter. According to this report, the patient was recommended to participate in a work hardening program. Updated documentation still failed to address the prior issue for non-certification, which is still unresolved. Furthermore, a specific employer/employee agreed upon return-to-work plan was not included in the records submitted. There is agreement with the previous determination, and the medical necessity of this request is still not established at this juncture.

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

Denial of 80 hours of work hardening is upheld/agreed upon since there is lack of clinical information regarding exhaustion of lower levels of care. There is no report of the number of post-operative physical therapy visits completed, compliance with attendance/exercise treatment/home exercises, or progress/plateau with basic rehabilitation visits. There is also a discrepancy between managing physicians according to the most recent submitted notes 12/3/13 and 12/5/13 with regards to plans for rehabilitation. There is also no notation with regards to medications - analgesic or psychotropic. There is no notation regarding goals for psychosocial stressors and means of achieving those goals such as via counseling. There is also no notation regarding vocational plan, such as whether there is even a job available to return to. Therefore, based on ODG criteria, the request for Work Hardening Program 80 Hours 5xWkx2 Wks Right Knee is not found to be medically necessary at this time.

PER ODG:

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 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.
(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.
(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 pain).
(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.

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)**