

Medical Assessments, Inc.

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Notice of Independent Review Decision

December 24, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The Reviewer is Board Certified in the area of Physical Medicine and Rehabilitation with over 16 years of experience.

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

Work Hardening Program 80hours/units

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that fell and twisted his right knee on xx/xx/xx. His diagnoses included sprain of the knee and leg and tear of the medial cartilage of the meniscus of the knee.

05/13/2014: Progress notes. Soft tissue palpation indicates a slight degree of hyper tonicity of the right knee. In addition, there is a slight tenderness and there is less perceptible swelling noted of the right knee. **Plan:** The patient tolerated the following procedures well. Manual therapy was administered to the right knee. The right knee received therapeutic exercise to improve range of motion. To retrain the affected musculature to increase mobility and strength, neuromuscular reeducation was administered to the right knee. Kinetic activity was administered to the right knee. Treatment was given to improve mobility.

05/29/2014: Progress notes. **Medications:** Trazodone 50mg, Bupropion 150mg, Gabapentin 400mg, Minoxidil 10mg. **Assessment:** S/P knee scope. **Plan:** Continue light duty and HEP. Start creams and vitamins.

06/01/2014: Progress notes. **PE:** Portal heals well from effusion. Using crutches. **Plan:** Start PT ASAP cont. narcotics wean off crutches. Stop Vicodin.

10/21/2014: Initial clinical interview and assessment. **Present Medication:** Lisinopril 10mg, Niacin Powder, Tizanidine. **HPI:** Claimant underwent one surgery for this injury. Claimant reports having completed PT and pre-and post-surgery. He reports weak, while working, with restrictions. Claimant reports his pain with being a 4. With medication the pain level is a 2, without medication the pain level is at a 7 at worst. Claimant describes his pain as burning in his right knee. **Functionally:** Claimant reports difficulty with acts of daily living to include yard work, driving more than 2 hours, sitting longer than 1.5 hours, walking more than 10 minutes, squatting, lifting/carrying more than 30lbs, climbing stairs, and playing sports with friends and his family. **Intrapersonal:** Claimant initially denies changes in self-perception, however, through further conversation alludes to some feeling of inferiority due to his limitation in physical activities, like sports with his children. Claimant denies both initial and sleep maintenance insomnia and early awakening. He reports sleeping 8 hours per night prior to the work injury, and currently sleeping 8 hours per night. He reports no change in appetite and a weight gain of 30-40 lbs., due to loss of function since the injury. He denies changes in alcohol and tobacco usage. He rated his overall functioning of life prior to the injury at 100% and rates his current level at 100%. He offers conflicting report, noting he no longer can engage in physical activities, like sports, that were a regular part of his family and social life. **Mental Status:** Claimant appeared appropriate for his stated age and well groomed. His psychomotor activity suggested slight agitation, as well as, ambivalent posture. Intellectual functioning was within normal limits. His mood was irritable. His affect was constricted. He did display cognitive distortions to include emotional reasoning minimization of difficulty, magnification of self. His memory for both recent and remote events was intact. His thought process was goal-directed. The claimant scored a 9 on the BD-II, indicating minimal depression. Claimant scored on a BAI was 3, reflecting minimal anxiety. Additionally, the claimant endorsed these 8 out of 9 DSM-5 symptoms for Major Depressive Episode as present most of the day, nearly every day. Mood- was irritable while his affect was irritable 3/10, anger 5/10, nervousness 4/10, sadness 1/10. Diminished interest or pleasure not playing sports with children. Change in weight 30-40lb weight gain. Psychomotor agitation or retardation slight agitation, ambivalent posture, irritability 3/10 anger 5/10 nervousness 4/10. Fatigue or loss of energy less participation in social outings and family activities, it is now both difficult and painful for him to play with his children. Feelings of worthlessness verbal report of feeling inferior as a father due to lack of physical ability. Diminished ability to think or concentrate- 6/10. **Diagnosis:** 296.22 Major Depressive Disorder, 300.82 Somatic Symptom Disorder.

Based on the information gathered through the initial interview without offices and the claimant's emotional presentation and verbal report, we would determine that

the work accident pain and ensuing functional limitations have caused this patient's disruption in lifestyle, leading to poor coping and maladjustment and disturbances in mood. The patient appears to have been functioning independently prior to the work injury of DOI: xx/xx/xx.

10/21/2014: Work hardening plan and goals of treatment. **Ability to participate in and benefit from treatment:** The claimant is well suited for involvement in a return to work program. Behavioral group therapy coupled with physical rehabilitation and work simulation, should improve the claimants prognosis much better than conditioning alone, as claimant demonstrates injury related psychological components that warrant multidisciplinary involvement. **Ability to return to/retain employment:** There does not appear to be any pathology that would impact a return to employment after the claimant functional tolerances are increased to a safe demand level. **Plan of treatment:** Treatment will include multidisciplinary, rehabilitation with physical behavioral modalities. The claimant will also participate in educational and process oriented group therapy with emphasis on relevant pain control techniques/strategies. The claimant should become involved in the work hardening program for a minimum of 20-30 days. **Summary:** The claimant sustained a work related injury. The claimant has exhausted conservative courses of treatment and is unable to return to prior levels of functioning and work. An objective FCE and behavioral evaluation confirms necessity of this program. The claimant requires, by medical necessity a comprehensive occupational rehabilitation program for successful return to work and medical case closure. The claimant has an agreed upon vocational goal. The claimant has a targeted job to return to. The claimant has met all accepted intensive rehabilitation program. The claimant has a realistic opportunity to benefit from this program and should be admitted immediately.

10/21/2014: Physical Performance Evaluation. **Medications:** Ibuprofen. **Functional Specific Testing:** Balance left leg- Dull ache. Pain level-3/10. Balance right leg- tightness. Pain level 4/10, pain increase. Crouch position- sharp ache. Pain level 5/10. Pain increase. Reach- pain level-dull. Pain level 3/10. No change. Sit- 30 minutes. Sharp ache. Pain level 5/10. Squat. Sharp Ache. Pain level 5/10. Decrease. Stand-30 minutes. Sharp ache. Pain level 5/10. Increase. Stoop- Tightness. Pain level 3/10. No change. **Assessments:** Although the claimant is currently working, they are unable to perform their regular job duties without the risk of further injury.

11/03/2014: Work Hardening Program Pre-Authorization request. The Functional Capacity Evaluation performed on 10/21/2014 reveals the claimant is functioning at a light-medium PDL and the job requires medium PDL. Claimant has shown modest improvement with outpatient physical therapy modalities and we are now recommending progression to a Work Hardening Program for progress to continue to be achieved. It is clear from the functional capacity evaluation that the current level of functioning due to injury interferes with the claimants ability to safely carry out specific tasks required at their workplace without risk of further injury and or aggravation of the condition. **Current Functional Deficits:** Job Level- Medium. Current Safe Work Capacity- Light-medium. The claimant DID

NOT MEET multiple medium level job requirements as defined by the US Department of Labor.

11/06/2014: UR. Rationale for denial: The patient is a male with a reported date of injury on xx/xx/xx. The mechanism of injury reportedly occurred when the patient fell twisting his right knee. His diagnoses included sprain of knee and leg, and tear of medial cartilage of the meniscus of the knee. Diagnostic studies included an official MRI of the right knee dated 06/07/2013 read, which was noted to reveal medial meniscus tear, an oblique tear extending to the anterior articular surface in the white zone and including the body of the medial meniscus. There was an oblique, radial portion extending to the superior articular surface. The lateral meniscus is intact. There was medial compartment narrowing and subchondral edema at the medial tibial plateau, with chondromalacia but no depressed fracture, and effusion noted. The patient previously participated in 6 postoperative PT sessions. There is a lack of documentation that the patient has exhausted all PT and reached a plateau. Therefore, the request for Work Hardening Program 80hours/units is non-certified.

12/02/2014: UR. Based on the clinical information provided the appeal request for work hardening program 80 hours/units are not recommended as medically necessary. The initial request was non-certified noting that the patient's date of injury is xx/xx/xx. There is insufficient information to support a change in determination, and the previous non-certification is upheld. Per telephonic consultation, there is no indication that the patient has exhausted lower levels of care. He underwent surgery and had 6 PT visits, pre and post-surgery. He has returned to work and apparently improved with what little PT he has received.

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

Determination: Denial of 80 hours of work hardening is UPHOLD/AGREED UPON since there is lack of lower levels of rehabilitative care with reports of only 6 Post-operative PT visits after undisclosed knee surgery and no documentation of progress or plateau with those visits. Furthermore, functional testing of only a half of a PDL category to meet MEDIUM job demands, psychometric testing of minimal depressive symptoms, and no habituating analgesic medications do not warrant the aggressiveness and extent of multidisciplinary rehabilitation. Therefore, the request for Work Hardening Program 80hours/units is non-certified.

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 [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.

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 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 hou

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 KNOWLEDGBASE**
- 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)**