

CASEREVIEW

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of Work Hardening for the 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:

Overturned (Disagree)

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 female who was injured on XX/XX/XX while she was walking to her XXXXXX. She tripped on XXXXX and fell to the ground landing on both knees.

On XX/XX/XX, the claimant presented with complaints of right and left knee pain. She described the pain as sharp and constant in the right knee and occasional soreness in the left knee. On examination, the right knee showed moderate-severe spasms, moderate-severe tenderness, moderate-severe decreased ROM and moderate-severe edema. Left knee revealed mild tenderness. X-ray of the right knee showed tripartite patella fracture. Assessment: 1. Unspecified fracture of right patella, initial encounter for closed fracture. Drug Rx: Medrol (pak), Naprosyn 500 mg, Tramadol 50 mg. Plan: Work restrictions: fully restricted from work. Refer to Orthopedics.

On XX/XX/XX, the claimant presented to XX, MD recommended pain medication, crutches and therapy.

On XX/XX/XX, MRI of the Right Knee, Impression: 1. A moderate sized knee joint effusion. 2. A 2.6 cm in length vertically oriented, nondisplaced fracture of the medial patella surrounded by mild bone marrow edema. 3. A moderate amount of fluid in the intercondylar notch surrounding the anterior and posterior cruciate ligaments. 4. Meniscal degeneration within the posterior horn of the medial meniscus. No tears are visualized in the medial or lateral menisci.

On XX/XX/XX, the claimant presented with continued pain. The pain is made worse with kneeling and bending. Symptoms are unaffected by or alleviated with rest. On examination of the right knee there was no joint line tenderness. Negative McMurray's medially and laterally. The extensor mechanism was intact. There was no

swelling. Pain with full flexion of the knee. Full ROM was present. Lachman and pivot shift were negative. Posterior drawer, valgus and varus stress were negative. Pain on PF compression was absent. Impression: Right knee patella fracture. Plan: Work on ROM, NSAID. No restrictions. Work status: Refer to XX. Weight bearing as tolerated.

On XX/XX/XX, the claimant presented for follow-up. On exam the right knee showed moderate-severe tenderness, moderate decreased ROM and moderate tension. Plan: FCE ordered. Work restrictions: Restrictions. Employer cannot accommodate the restrictions. Work Status: Full Time Light Duty 3 weeks x 1. Therapy: 2 times per week for 2 weeks.

On XX/XX/XX, the claimant underwent an FCE. Occupation listed: Cafeteria Manager. Occupation requires she perform at a Medium PDL. Based on the result she was able to safely and dependably perform the following: 1. Ability to lift/carry at Sedentary-Light PDL (15 lbs. from floor to waist, 15 lbs. from waist to shoulder, carry 15 lbs.). 2. Ability to push/pull at Light-Medium PDL. 3. Occasionally stand/walk. 4. Limited ability to bend/stoop. 5. Frequently reach up/out.

On XX/XX/XX, the claimant presented for frequent pain in her right knee. She reported that she was getting better. She reported therapy was helping. It was noted she had completed all lower level care and did not have follow ups scheduled. On examination of the right knee she had moderate tenderness medially and moderate decreased ROM. Plan: Work restrictions. Recommended transitional care to help prepare her to return to work. Current medication: 1. Medrol 4 mg tablets in dose pack. 2. Cyclobenzaprine 10 mg. 3. Naprosyn 500 mg. 4. Tramadol 50 mg.

On XX/XX/XX, the claimant presented for a psychological evaluation. She rated her pain level as 3/10. Brief Pain Inventory (BPI) showed: General Activity 3/10, Mood 2/10, Walking Ability 1/10, Normal Work has improved and was 10/10, Relations with other people 0/10, Sleep has not improved and was 0/10, Enjoyment of life 0/10. FABQ PA was 11 which is below the cutoff of 19. Her FABQ W was 23 which is below the upper cutoff of 34. Pain Outcomes Profile (POP): Mobility 27; negative affect 10; ADLs 0; Fear 75; Vitality 57; Physical Index 28; Affective Index 43. These results indicated that the claimant perceived herself more emotionally than functionally impaired by her pain. Impression: There are psychological involvement with her chronic pain. But there was no evidence of a thought disorder. She had not progressed sufficiently to be taken off work. She wants to go back to work where her employer still has a position available for her. She appeared to be doing about as well as she was capable of doing. It was opined she would benefit from Work Hardening Program.

On XX/XX/XX, UR. Rationale for Denial: First, the records do not include an employer verified job description. The claimant's occupation is listed as "XX." The Official Disability Guidelines requires an employer verified job description before entering a multidisciplinary program. Second, the documentation fails to outline behavioral issues in need of a multidisciplinary program. In fact, the psychological evaluation recommends a Work Conditioning Program. Furthermore, XX recommends "no restrictions."

On XX/XX/XX, UR. Rationale for Denial: The previous non-certification on XX/XX/XX was due to lack of a job description and lack of behavioral issues outlined. The previous non-certification is supported. Additional records included an appeal on XX/XX/XX. Official Disability Guidelines requires an employer verified job description before entering a program. Records do not reflect the claimant is not a candidate for lower levels of care such as a work conditioning program as required by the guidelines. The claimant has returned to work without restrictions. Records do not reflect the claimant meets the requirements of a work hardening program. The request for an appeal of 80 hours of a work hardening program is not certified.

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 OVERTURNED/DISAGREED WITH since submitted job

description with fax stamp of XX/XX/XX confirmed MEDIUM job demands of minimal lifting requirement of 50 lb. versus FCE XX/XX/XX notable for SEDENTARY/LIGHT ability lifting of 15 lb. along with documented psychosocial barriers of sleep disturbance and fear avoidance (elevated FABQ PA 11 and FABQ W 23), documentation of job availability and motivation to return to work, thereby meeting ODG criteria for medical necessity for progression to more physically aggressive and multi-disciplinary work hardening program in order to successfully and safely return to work.

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 [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 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 co

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)**