Understanding and Interpreting an FCE
An FCE needs to be objective, non-biased, evidence-based in order to be fair to the injured worker and referral source.

The goal is to obtain a “valid” FCE
Other Common Test Names

• Work Tolerance Screening (WTS)
• Functional Abilities Evaluation (FAE)
• Functional Capacity Assessment (FCA)
• Work Capacity Evaluation (WCE)
FCE Purpose: Provides objective data to assess Capabilities and Limitations

• The report needs to answer the referral question????
• Is the patient giving effort that is maximum or near maximum effort in order to accurately determine:
  • Work Status
  • Work Placement
  • Settlement
  • Determine next course of action
    • Surgery
    • Other medical interventions
    • Missed diagnosis

A Physican should avoid placing arbitrary restrictions on abilities without objective assessment and measurement
FCE

• Assesses
  • Validity/Reliability
  • Consistency of Effort
  • Quality of effort

PROBLEM: What do we do when the patient does not give “good” objective effort
Who Should Perform an FCE?

• May be dependent on state practice act guidelines

• Needs to be a provider who has the *clinical* expertise and can legally provide a clinical opinion
  • Analyze, interpret and conclude by answering referral question

• Provider needs to be objective/non biased-Should not be “treating” clinician

• Provider needs to have knowledge to consider all components (medical history, current medical condition, etc)
Who Should Perform an FCE?

PTA/COTA
Occupational Therapist
Athletic Trainer
Ergonomist
Physical Therapist
Kinesiologist
Exercise Physiologist

The FCE needs to be defensible in court
Check the signature line
## Indicators for FCE

### Medical
- Job involves repetitive work task
- Job involves Medium to Heavy work
- Complaints of pain with no substantiated clinical findings
- Plateau in PT/OT
- Medical (MMI)
- Decreased work tolerance

### Behavioral
- Off from work 3 months or more
- Loss of past work habits and self-confidence
- Fear of re-injury
- Negative attitude about returning to work
- Questionable legitimacy of injury
- Suspected sub-maximal effort
- Lack of progress in physical/occupational therapy without clear objective reasoning
- Lack of participation in therapy

### Legal
- Objective documentation needed to return to work
- Return to work will require job modification
- Conflict of medical opinion about worker’s status
Patients referred for FCE & WCE need to medically stable:

- Resting HR greater than 100 bpm
- Blood pressure not greater than 160/100
- Pain has stabilized
- Able to tolerate activity-2 hours
- Soft tissue healing will not jeopardized with maximum tolerance testing

<table>
<thead>
<tr>
<th>Stages</th>
<th>Systolic</th>
<th>And/OR</th>
<th>Diastolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prehypertension</td>
<td>120-139</td>
<td>OR</td>
<td>80-89</td>
</tr>
<tr>
<td>High Blood Pressure Stage 1</td>
<td>140-159</td>
<td>Or</td>
<td>90-99</td>
</tr>
<tr>
<td>High Blood Pressure Stage 2</td>
<td>160 or higher</td>
<td>Or</td>
<td>100 or higher</td>
</tr>
</tbody>
</table>
focus
FCE Approaches

• Psychophysical Approach:
  Subjective complaints determine progression of tolerance testing.
  It is not based on the presence or absence of mechanical changes or deficits witnessed.
  Client is in charge of the testing process.

• Kinesiophysical Approach: Athletico (previously Accelerated)
  Mechanical changes or deficits need to correlate with the subjective pain complaints.
Kinesiophysical Approach cont’d.

• Evaluator Determines stopping point
  • Based on the observation of mechanical changes which should be observed when max effort is given.
  • Based on our medical knowledge of biomechanics, diagnosis, physiology, anatomy, & cardiovascular endurance

• If Client terminates task before a mechanical change is noted and or kinesiophysical signs are observed, it can be assumed that maximum effort was not given on that specific task.
Different Types of FCE’s (should be part of the referral question)

• **Baseline FCE**
  - Assessment of the functional ability to perform the spectrum of work tolerances related to the physical demand factors of job tasks
  - Best suited when restricted duty is available or RTW to previous job is highly improbable
  - MMI, disability, vocational re-training/assessment

• **Job-specific FCE**
  - Assessment of the match between the client’s functional capabilities and the critical demands of a specific job
  - Answers the referral question - “Can the client return to work to the previous job?”
  - Accomplished by evaluating work tolerances with specific parameters and the use of structured work simulations
Different Types of FCE’s Cont.

- **UE FCE**
  - Initiated with M-S Eval
  - Assessment of only the physical capabilities and tolerances that incorporate UE usage
  - Will not evaluate sitting, standing, stoop, squat, kneel, crouch, etc.

- The referral source should speak to the therapist upon making the referral so the evaluation is scheduled with the most appropriate therapist.
Value of Providing Job Description for Job-Specific FCE

- Provides accurate parameters for RTW
- Ensures that client will only be assessed on tolerances specific to job
- Ensures that the evaluator will be able to establish recommendations, which are appropriate and reasonable for the job/employer
Accurate job description is critical

Goal: request a functional job description with job demands at time of initial evaluation

If no job description is available, therapist receives job information from the Injured Worker

Athletico can send a copy of this form to the employer
Need to know if patient can do this task when they return? --- Job Specific - Need Job Description
Evaluation Process
How long does it take?
What is assessed?

• 4-6 hours in duration

• Review medical record—Important to get accurate description of injury and review medical records—(Previous therapy, surgeries, history, etc)

• Pain and activity/disability questionnaires
  • Gain insight to why observed limitations may be disproportionate to objective finding.

• Musculoskeletal evaluation

• Non material handling assessment-repeated movements

• Objective Functional testing-lifting/carrying/job sim

• Repeat testing of 1 & 2 hand lifting performance-throughout FCE –confirms abilities

• Job Simulation Tasks or Functional Circuit-confirms ability previously assessed during the FCE
Why is a M-S Evaluation important as part of an FCE

• Should be part of all FCEs - Check with your provider
• Determines whether client meets admission criteria
• MS evaluation allows Evaluator to distinguish between limitations in performance due to impairment or lack of effort without any MS findings to support the observation – Is there a correlation?
  • Evaluator may not know why (fear, anxiety)
  • Ex: Knee diagnosis: may have difficulty getting into a full squat due to limitations in ROM. (FCE evaluator would not know this if they did not measure it during a MS evaluation)
• Assists in predicting functional performance
• Client may need “good” PT before proceeding
Evaluation: Physical Tolerance Testing

- Floor to Waist
- 12” to Waist
- Waist to Shoulder
- Shoulder to Overhead

- Non material handling Activities
  - Sitting, standing, reaching, kneeling, squatting, bending, ladder, stairs,

- Balance Assessment
  - Static and Dynamic
Job Simulation
Tasks/Functional Activity Circuits

• Performed to assess tolerance to perform tasks outside of standard lifting parameters

• Job Specific

• Functional Activity Circuit
  • Usually 30-60 minutes
  • Verifies weights observed during formal tolerance testing, assesses endurance, allows evaluator to make recommendations for work tolerances.
How do you know if the client is exerting a “good effort” which is representative of their abilities?

- Skill of evaluator-ask !!!!!
- Battery of tests
- Observation throughout FCE
  - Walking into the facility
  - Sitting tolerance while filling out paperwork
- Pain and Activity Questionnaires
  - Assess clients perception of their pain and disability

Objective testing
- Musculoskeletal exam
- Function testing
- Circuit/Cross Reference lifting
- The greater the number of battery of tests, the more likelihood to observe consistent behaviors.
Critical FCE Metrics- Every FCE methodology has internal rating system - No standard

Metrics:
• Consistency of Effort
• Reliability of Pain/Performance
• Quality of Effort

Most Common

Athletico has 3 areas of objective measurement that is gathered during the assessment. Many testing methodologies combine it into 2
3 Effort Metrics Definitions

• **Consistency of Effort** = Reproducibility - or the likelihood that an effort may be copied, duplicated, or produced as a close imitation, in a series of trials.

• **Quality of Effort** = Degree - or the extent, level, or scope of a subject's volitional exertion in maximal or repetitive testing.

• **Reliability of Pain-Non-Organic Signs** = descriptions or expressions of pain or symptomatology that do not subscribe to the scientific laws of living organisms.
How is Maximum Effort Determined?

- Research is conflicting
- The more measures in an FCE and the experience of the evaluator promotes a more accurate result
  - Cross reference tasks, gross inconsistencies,
  - Multiple methods during testing
- Goal: Objective FCE designed to assess true physical capabilities based on the performance of good and or maximum effort
- Requires a thorough knowledge of what is expected for the condition in question and the capacity to observe or elicit what is expected and what is not.
Reliability

Reliability of Pain-Approx 72 criteria if everything is tested (Athletico)

• Pain & Activity Questionnaires
• Observational Findings
  • ROM in MS eval compared to ROM when not directly tested
• Mechanical Changes associated with Functional Pain Increase
• RPE vs HR Comparison

Examples

Is claimant always having difficulty assuming positions of squatting
If limp is consistent throughout the exam
Cross referencing maximum lifting (2 hand lift)
Perception of pain/abilities consistent with performance
Consistency of Effort

• Important to have a battery of objective tests-dispersed throughout FCE
• Research-based tests that can withstand a legal challenge
• Fewer tests contribute to the propensity for inappropriate interpretation
• Consistency of Effort-38 criteria if everything is tested (Athletico)
  • Manual Material handling sequencing-Ex: Occ > Freq
  • CoVs - Spinal Inclinometer, Jamar, & Static Strength testing, pinch
  • Bell Shaped Curve – Jamar, Rapid Grip
• Repeated movements: overhead reach, squatting, bending
• Should observe same behaviors and limitations throughout the test.
Example of inconsistent observation
Consistent ROM noted with different tasks == consistent performance
Quality of Effort

• Quality of Effort—74 criteria if everything is tested (Athletico)
  • 2-3 Kinesiophysical Signs noted which demonstrates good effort-evidence based
  • Heart Rate Variance >25% from Resting Heart Rate
  • Self terminated without clinical objective findings—if client did not attempt, refused, or stopped before any mechanical change noted—Not a quality effort
Kinesiophysical Signs - Quality of Effort

- Muscle Recruitment
- Body Mechanics
- Base of Support
- Counterbalance
- Control & Safety
- Heart Rate
Expected & Unexpected Results

Every activity that is performed in an FCE should be evaluated against a metric. --FCEs should be objective and non biased.

• **Expected results =**
  • What the therapist should see if the patient is giving good effort and there are objective findings to substantiate pain ratings or there are objective findings to substantiate acceptable, observed quality of effort

• **Unexpected Results =**
  • When Client is not giving full effort
  • there are no kinesiophysical signs or Mechanical Changes
  • Terminates activity without increase in pain or objective findings
  • Response does not correlate to diagnosis
• Every activity in an FCE has a purpose.
• Overall results/Performance is analyzed to determine an overall “rating” that classifies performance
• Important to have many tests and not base results on one parameter
Results: FCE Performance Overall Rating - based on Combined Total Effort

Every system has their own internal grading system. What is most important is that testing methodology is consistent and principles are built on evidence-based research.

- 80--100% = Consistent Performance/Acceptable Effort
- 70-79.99% = Variable Performance /Questionable Effort
- 0--69.99% = Inconsistent Performance /Unacceptable Effort
Performance Criteria Definitions

- **80-100% - Consistent Performance/Acceptable Effort** indicates that the client’s perceived limitations, and return to work confidence are not negatively affecting symptom expression, consistency of effort, reliability of pain, and/or quality of effort. Data obtained is near or equal to the Client’s true status. The evaluator is confident in projecting full time work tolerances.
Most Difficult – What do we do?

- **70% - 79.99% Variable Performance / Questionable Effort**

- Variable Performance / Questionable effort indicates that the client’s perceived limitations and return to work confidence are mildly to moderately affecting symptom expression, consistency of effort, reliability of pain, and/or quality of effort. The client likely could have performed at higher levels than willing during musculoskeletal and functional testing. The client can perform on a full time basis at least at levels identified in this report.
• **0--69.99% Inconsistent Performance / Unacceptable Effort**

• Inconsistent Performance/Unacceptable Effort indicates the Client’s perceived limitations and return to work confidence are markedly affecting symptom expression, consistency of effort, reliability of pain, and quality of effort. The client could have performed at markedly higher levels than willing during musculoskeletal and functional testing. Behavioral factors are affecting evaluation results to such a degree the evaluator cannot identify the client’s true musculoskeletal status, project full-time work tasks and/or true impairment. The physician will determine final disposition after review of this report and other relevant medical findings.
So Now What?

Reader has to be able to interpret the report.

Interpret information, Overall Performance

What are the recommendations?
Was referral question answered?

What is important:
Can the end user interpret the report?
Report needs to be end user friendly -- communicate information easily.

Thank you for the referral of Cindy TEST_NUM_1 to Athletico's Algonquin center. Per your request a Job Specific Functional Capacity Evaluation was performed on 10/20/2014.

<table>
<thead>
<tr>
<th>Performance Relative to Job Demands</th>
<th>Performance Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.91% (9/22 Job Demands Met)</td>
<td>Inconsistent Performance / Unacceptable Effort (41% or 28/69 Expected Responses)</td>
</tr>
</tbody>
</table>

**Physical Demand Level**

Client demonstrates the physical capabilities and tolerances to function at least in the Heavy physical demand level. The physical demand level is determined by a 2 hand occasional lift of 80# to waist and 75# from floor to waist level and 2 hand frequent waist to shoulder lift of 30#.

Job description was provided by employer. The physical demand level of the job is a Very Heavy physical demand level. The physical demand level is determined by a 2 hand occasional lift of 95# to waist and a 2 hand occasional lift of 89# from floor to waist and a 2 hand frequent lift of 40# from waist to shoulder. NOTE: it is the frequent lift of 40# that places client in the Very Heavy Physical Demand Level.

**Recommendations**

MS. TEST IS FUNCTIONALLY EMPLOYABLE. GIVEN THE FACT THAT SHE DEMONSTRATED 41.00% OF COMBINED EFFORT (28 EXPECTED/69 TOTAL TESTS), SHE IS CAPABLE OF GREATER FUNCTIONAL ABILITIES THAN DEMONSTRATED DURING THIS FCE.

**Job Demands Match Table**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Client Performance</th>
<th>Job Demand</th>
<th>Job Demand Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor to Waist Lift Occasional</td>
<td>75.00#</td>
<td>95.00#</td>
<td>Unmet</td>
</tr>
<tr>
<td>12” to Waist Occasional</td>
<td>80.00#</td>
<td>89.00#</td>
<td>Unmet</td>
</tr>
<tr>
<td>Waist to Shoulder Lift Occasional</td>
<td>45.00#</td>
<td>50.00#</td>
<td>Unmet</td>
</tr>
<tr>
<td>Overhead Lift Occasional</td>
<td>25.00#</td>
<td>30.00#</td>
<td>Unmet</td>
</tr>
<tr>
<td>Floor to Waist Lift Frequent</td>
<td>35.00#</td>
<td>50.00#</td>
<td>Unmet</td>
</tr>
</tbody>
</table>
## Quality of Effort
(pertains to the extent or scope of a subject’s volitional exertion in maximal or repetitive testing)

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working v. Resting HR</td>
<td>During repeated periods of maximum effort testing, working HR values should increase above resting HR. A minimum increase of at least 25% above the resting HR would be expected in a majority of trials to indicate full effort was provided.</td>
<td>0/11</td>
</tr>
<tr>
<td>Kinesiophysical Observations</td>
<td>Changes with movement patterns should be observed during periods of maximum effort testing. A minimum of 2 observations (altered base of support, recruitment of accessory muscles or counterbalancing) during a majority of tasks would be expected in instances of full effort.</td>
<td>2/7</td>
</tr>
<tr>
<td>Self-Termination of task-non</td>
<td>Effort cannot be rated due to client terminated activity without clinical objective findings.</td>
<td>0/1</td>
</tr>
<tr>
<td>material handling/Job Simulated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>tasks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Quality of Effort Details

<table>
<thead>
<tr>
<th>Type</th>
<th>Category</th>
<th>Expected</th>
<th>Unexpected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinesiophysical Signs</td>
<td>12” to Waist Lift (Frequent)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Kinesiophysical Signs</td>
<td>12” to Waist Lift (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Kinesiophysical Signs</td>
<td>Bilateral Carry (Occasional)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Kinesiophysical Signs</td>
<td>Floor to Waist Lift (Frequent)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Kinesiophysical Signs</td>
<td>Floor to Waist Lift (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Kinesiophysical Signs</td>
<td>Overhead Lift (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Kinesiophysical Signs</td>
<td>Waist to Shoulder Lift (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>12” to Waist Lift (Frequent)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>12” to Waist Lift (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>Bilateral Carry (Frequent)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>Bilateral Carry (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>Floor to Waist Lift (Frequent)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>Floor to Waist Lift (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>Overhead Lift (Frequent)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>Overhead Lift (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>Waist to Shoulder Lift (Occasional)</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>HR Variance</td>
<td>Fork Lift Climb</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Type</td>
<td>Description</td>
<td>Score</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Cog-Wheel Muscle Release</td>
<td>The presence of cog-wheeling or ratchet-like resistance during manual muscle testing suggests the presence of volitional motor weakness.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Pre-Test Pain Level</td>
<td>High pain ratings should be consistent with altered movement patterns, range of motion and behaviors including a willingness to test despite high pain reports.</td>
<td>Score = 2</td>
<td></td>
</tr>
<tr>
<td>Visual Analog Scale vs. Numeric Pain Scale</td>
<td>Responses to these scales should have a direct correlation in order to be consistent.</td>
<td>Not Within Range</td>
<td></td>
</tr>
<tr>
<td>Ransford Pain Drawing (lumbar)</td>
<td>Reports of circumferential pain, glove or stocking presentation would in most cases be supported in the literature as inconsistent with the diagnosis.</td>
<td>Score = 5</td>
<td></td>
</tr>
<tr>
<td>Modified Oswestry Low Back Disability Questionnaire</td>
<td>In the absence of organic findings, high-perceived disability may compromise recovery from injury.</td>
<td>Score = 36.00%</td>
<td></td>
</tr>
<tr>
<td>Observational Findings</td>
<td>Subjective pain reports and ROM/strength deficits should correlate to performance with associated tasks and/or behaviors in the clinic.</td>
<td>Score = 5/2</td>
<td></td>
</tr>
<tr>
<td>RPE vs HR Comparison</td>
<td>A patient’s report of physical exertion should correlate with a corresponding increase in working heart rate.</td>
<td>Score = 5/10</td>
<td></td>
</tr>
<tr>
<td>Functional Pain Scale Changes and Mechanical Observations</td>
<td>Mechanical changes with movement or performance are expected with an associated functional pain scale increase.</td>
<td>Score = 3/7</td>
<td></td>
</tr>
</tbody>
</table>

### Reliability of Pain Details

<table>
<thead>
<tr>
<th>Type</th>
<th>Category</th>
<th>Expected</th>
<th>Unexpected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliability of Pain Criteria</td>
<td>Cogwheel Muscle Release (lumbar)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Reliability of Pain Criteria</td>
<td>Oswestry Low Back Disability Questionnaire</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Reliability of Pain Criteria</td>
<td>Pre-Test Pain Level</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Reliability of Pain Criteria</td>
<td>Visual Analog Scale vs Numeric Pain Scale</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Reliability of Pain Criteria</td>
<td>Ransford Pain Drawing</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Observational Findings</td>
<td>Do client’s functional movements correlate to reported pain symptoms?</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Observational Findings</td>
<td>When using the FPS during testing, are there 3 or more tasks where score did not correlate to functional deficits?</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Mechanical Changes Associated with Functional Pain Scale Increase</td>
<td>Bending</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Mechanical Changes Associated with Functional Pain Scale Increase</td>
<td>Forward Reach</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Mechanical Changes Associated with Functional Pain Scale Increase</td>
<td>Floor to Waist Lift (Frequent)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Mechanical Changes Associated with Functional Pain Scale Increase</td>
<td>Overhead Lift (Occasional)</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Mechanical Changes Associated with Functional Pain Scale Increase</td>
<td>Waist to Shoulder Lift (Occasional)</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
## Determining Physical Demand Level:

<table>
<thead>
<tr>
<th>PHYSICAL DEMAND LEVEL</th>
<th>OCCASIONAL</th>
<th>FREQUENT</th>
<th>CONSTANT</th>
<th>WALKING/CARRYING</th>
<th>TYPICAL ENERGY REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-33% OF WORKDAY</td>
<td>0-100 Reps/day</td>
<td>34-66% OF WORKDAY</td>
<td>67-100% OF THE WORKDAY</td>
<td>500+ Reps/Day</td>
<td>Greater than 5.5 hrs/day</td>
</tr>
<tr>
<td>0-2.5/hrs/day</td>
<td>Up to 12.5/lifts/hour</td>
<td>2.5-5.5 hrs/day</td>
<td>Greater than 62 lifts/Hour</td>
<td>1 lift/min or greater</td>
<td></td>
</tr>
<tr>
<td>0-100 Reps/day</td>
<td>1 lift every 5 min</td>
<td>101-499 Reps/day</td>
<td>500+ Reps/Day</td>
<td>1 lift every 5 min to 1 lift every min</td>
<td></td>
</tr>
<tr>
<td>0-2.5/hrs/day</td>
<td></td>
<td>12-62 lifts/hour</td>
<td></td>
<td>1 lift every 5 min</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 lift every 5 min to 1 lift every min</td>
<td></td>
<td>1 lift every 5 min</td>
<td></td>
</tr>
</tbody>
</table>

| SEDENTARY | 10 LBS OR LESS | Negligible | Negligible | Negligible | 1.5-2.1 METS |
| LIGHT     | 20 LBS         | 10 Lbs. and/or walk/stand/push/ pull of arm/leg Controls | Negligible and/or push/pull of arm/leg controls while seated | 2.5 MPH. NO GRADE OR SLOWER SPEED WITH 10 LBS OR LESS | 2.2-3.5 METS |
| MEDIUM    | 20-50 LBS      | 10-25 LBS   | 10 LBS     | 2.5-3.5 MPH. NO GRADE OR SLOWER SPEED WITH 25 LBS OR LESS | 3.6-6.3 METS |
| HEAVY     | 50-100 LBS     | 25-50 LBS   | 10-20 LBS  | 3.5 MPH WITH 50 LBS OR LESS LOAD | 6.4-7.5 METS |
| VERY HEAVY| IN EXCESS OF 100 LBS | Over 50 LBS | Over 20 LBS | 3.5 MPH WITH 50 LBS OR MORE LOAD | Over 7.5 METS and up to 12 METS |

1993 Leonard N. Matheson, PHD
Department of Labor
Combination from Accelerated/Athletico Clinical Experience, Worksteps, DOL,
Value of Results

Decision Making Process

Maximum effort: Consistent, Reliable performance
- Can accurately define functional performance level-PDL
- Determine if further care is appropriate as identified in the musculoskeletal exam
- Misdiagnosed?
- Triage to work conditioning
- Job coaching to return to work
- On site job analysis
- RTW –
- Case closure

Not consistent in effort and reliability is in question/invalid
- Objective findings do not correlate with subjective complaints
- Physician to determine medical course of action
- Accurate physical demand level is unable to be obtained due to lack of maximum effort.
- PDL level unable to be determined
- Inform the claimant
- IME
- Return to Work
- Case Closure
Common Questions from Customers

- Do I need an FCE?
  - Need an FCE to determine current level of function
  - FCE will help determine appropriate course of treatment
  - Identify if patient is reliable/consistent
    - Work conditioning
    - Return to work
    - Job consultation
    - Job coaching

- Can you put my client in a work conditioning program without doing an FCE? **YES**
  - Goal is to promote success and compliance
  - Patient is learning how to transition from PT to work conditioning
  - Evaluation should be a submax level to determine safe/acceptable starting point in Work Conditioning
  - Start in program—provide supervision, proper progression and goal planning and defining expectations.
Can you put my client in a work conditioning program if the FCE results showed inconsistent/invalid results?

May do a 1 week trial to see if behavior changes

May do 1 week if physician or insurance company needs to gather more objective information on behavior patterns.
Common Questions from Customers

- Do I need an FCE after a Work Conditioning Program?
  - Not if the work conditioning program is comprehensive and provides a discharge report that reports abilities compared to job requirements.
  - Why assess effort if client was successful in a program and has met job demands within a program.
Why do therapy companies request medical records? Value of forwarding medical diagnostics and or medical records to evaluating therapist--

- Ensures accuracy of informative vs. client self-report
- Provides timeline sequences of medical involvement
- R/O’s need for additional medical and therapeutic intervention—avoids inappropriate recommendations