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IRO REVIEWER REPORT

DATE OF REVIEW: 05/21/07

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Items in Dispute: Twenty (20) sessions of work conditioning.

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

Texas License and currently on TDI DWC ADL.
Diplomate of the American Association of Quality Assurance & Utilization Review Physicians
Diplomate of the American Academy of Pain Management
Certified by the American Academy of Disability Evaluating Physicians
Fellow of the American Back Society

REVIEW OUTCOME:

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Neurosurgical office notes from M.D., dated 06/02/04.
2. Cervical and shoulder MRI dated 06/16/04.
3. Sports medicine notes from D.O., ranging between 08/10/04 and 09/20/04.
4. Review of medical history and physical examination dated 09/28/04.
5. Designated doctor report dated 09/28/04.
6. Additional records from D.O., between 10/18/04 and 12/14/04.
7. M.D., records from 01/14/05 through 01/15/05.
8. Operative report dated 03/24/05 for the cervical spine.
9. 04/15/05 radiographs.
10. Spine & Rehabilitation narrative notes from 05/05/05 thru 12/17/06. This includes records from M.D., and D.C.

11. EMG/NCV study dated 06/16/05.
12. Neurosurgical consultation with M.D., dated 05/25/05.
13. Additional office notes from Spine & Rehabilitation dated 05/27/05 thru 04/10/07.
14. M.D., impairment rating letter dated 06/17/05.
15. Upper extremity evoked potential study dated 06/24/05.
16. Spine & Rehabilitation narrative notes for dates of services 06/30/05 thru 09/01/06.
17. Shoulder arthrogram dated 11/03/05.
18. Operative report for the right shoulder dated 11/22/05.
19. M.D., records of 03/21/06.
20. M.D., report of 03/27/06.
21. M.D., pain management records of 05/10/06.
22. Additional pain management records from M.D., dated 07/07/06.
23. EMG/NCV study dated 10/30/06.
24. Repeat MRI of the cervical spine dated 11/21/06.
25. Additional neurosurgical records from M.D., dated 11/30/06.
26. preauthorization denials dated 03/15/07 and 03/22/07.
27. Spine & Rehabilitation Center notes requesting reconsideration for work conditioning.
28. letter of IRO dated 05/04/07.

INJURED EMPLOYEE CLINICAL HISTORY (SUMMARY):

Based on the records reviewed, this employee sustained an occupational injury. The employee was employed by Inc. as a housekeeper, and during the normal course of her occupation, she was lifting trash bags out of a trash can on a repetitive basis. The employee indicated that after performing her regular duties, she gradually developed pain in the right shoulder and neck region which resulted in difficulty lifting the right arm.

An emergency room visit was documented on 05/08/04, and the employee was provided with an IM medication, but radiographs on that date were considered normal.

By 05/16/04, the employee went to her primary care doctor, Dr.

Dr. an orthopedic physician documented right shoulder pain and neck pain, and by 06/16/04, Dr. documented some numbness in the right first, second, and third fingers,
along with pain in the right arm and difficulty raising the right arm and using the right arm due to pain in the neck.

An initial MRI of the right shoulder documented on 06/16/04 revealed a small focal full thickness rotator cuff tear. A cervical spine MRI on the same date revealed some cervical spondylosis with a small disc protrusion at C6-C7 and C7-T1 areas. There was also a moderate to severe amount of central spinal stenosis at C6-C7. Uncovertebral osteophytes were also present and the cord was flattened at C7-T1.

Physical therapy was started at that time, and the employee was placed on Ultracet.

By August, 2004, the employee underwent a course of epidural steroid injections by Dr.. A third epidural steroid injection was recommended on 09/20/04.

On 09/28/04, the employee was evaluated by M.D. Maximum Medical Improvement (MMI) was reached at that time with a 5% whole person impairment rating. The rationale for MMI was based on the employee's signs of symptom magnification and limited effort during his examination.

The employee continued treating with Dr. and on 10/18/04, Dr. wrote a letter disputing the date of MMI. He also provided an injection into the subacromial bursa at that time.

By December, 2004, the employee was referred to an orthopedic surgeon, Dr. His examination was performed 01/14/05, and at that point, he noted that the employee had 0 degrees of abduction with only 10 degrees of forward flexion. Surgical treatment was recommended to include decompression and rotator cuff repair with distal clavicle resection. However, Dr. did indicate that the prognosis was fairly poor and guarded due to objective signs of radiculopathy.

It appears that the employee next began treating with Dr. a neurosurgeon. On 04/04/05, the employee underwent an anterior cervical discectomy with fusion with right iliac crest graft and anterior plating at C4-C5, C5-C6, and C6-C7. Postoperative evaluations by Dr. revealed that radiographs on 04/15/05 confirmed satisfactory positioning of fusion material.

A postoperative EMG/NCV study was performed on 06/16/05, and the impression was that of acute irritability in the bilateral C5, C6, and C7 motor root distributions, with C6 being the most involved area. There was also indication of reinnervation that was ongoing but no acute denervation at that time. Other incidental findings included slight irritability in the left median and ulnar intrinsic muscles, but no significant pattern reduction and only a borderline slowing of the left median sensory latency during the F-wave.

A repeat impairment evaluation was performed by Dr. on 06/17/05. At that point, Dr. suggested that the claimant actually had a 25% whole person impairment rating due to the surgical intervention that had occurred as a result of her occupational incident.

Another repeat upper extremity electrodiagnostic study was performed on 06/24/05, which consisted of an evoked potential. Dr. performed this study, and it was found to have no abnormalities.

The employee reentered the office of Dr. and by 11/03/05, she underwent an MRI arthrogram of the right shoulder which revealed a moderate sized full thickness rotator cuff tear. As of 11/22/05, she underwent a right shoulder arthroscopy, debridement, acromioplasty, and distal clavicle resection with rotator cuff repair.

Following her surgeries, the employee was referred to Dr. for another orthopedic consultation. The date of visit was 03/21/06, and at that point, "She had some stiffness of her neck but no upper extremity symptoms at this point in time". Apparently, she was now complaining of right lower extremity pain which radiated to the right hip. An MRI had apparently also been done which revealed an L4-L5 spondylolisthesis with a contained disc herniation. Dr. felt that the employee might have a surgical neuroma at the site of the bone graft, along with myalgia paresthetica, and therefore, he recommended injections to the lateral femoral cutaneous nerve.

The employee was ultimately referred to M.D., for a pain management evaluation. Dr. treated the employee for her right femoral cutaneous nerve symptoms, and he performed injection to this region as well as to the right trochanteric region for trigger points and bursitis.

Dr. followed up with the employee on 07/07/06, and he suggested that she still had pain levels of up to 5/10 in the right hip, but that the prior injection had provided "excellent relief of pain".

Another electrodiagnostic study was performed on 10/30/06. In the upper extremity there were no abnormalities noted in the trapezius or levator scapular muscles, but there was evidence of low grade chronic motor radiculopathy in the C5 and C6 motor roots. There was also some acute irritability in the bilateral C7 motor roots.

A narrative report of the EMG study also suggested that the claimant had removal of her surgical hardware performed sometime around July or August, 2005.
A repeat cervical MRI study performed on 11/21/06 confirmed developmental narrowing of the central cervical canal along with moderate narrowing of the right and mild narrowing of the left neural foramen at C4-C5. A C5-C6 3 mm subligamentous disc herniation was also still noted with bilateral foraminal encroachment. Finally, at the level of C6-C7, there was a 4 mm right parasagittal and foraminal disc herniation which did impinge upon the right C7 nerve root.

A note written by Dr. on 11/30/06 suggested that the claimant never had any postoperative physical therapy. However, surgery was apparently performed on 04/04/05, August, 2005, and November, 2005 according to the records. It should also be mentioned that the records clearly indicate multiple dates of physical therapy provided at Spine & Rehabilitation Center during that same timeframe. Nevertheless, Dr. referred the claimant for physical therapy as of 11/30/06.

By 03/15/07, a request for work conditioning had been denied. A rebuttal letter received a second denial on 03/22/07.

When reviewing records from Spine & Rehabilitation Center between 05/05/05 through at least 04/10/07, it appears that physical therapy had been ongoing between the dates of at least 05/31/05 through 05/09/06. This is a twelve month timeframe where physical therapy modalities had been performed by Spine & Rehabilitation Center. Records on 06/30/05 suggested the employee had a pain level of 6/10 in the right neck and shoulder region. Range of motion in the cervical spine was 33 degrees of flexion, 28 degrees of extension, 30 degrees of left lateral flexion, 28 degrees of right lateral flexion, 36 degrees of left rotation, and 38 degrees of right rotation. With regard to the right shoulder, flexion was limited to 110 degrees, extension was limited to 30 degrees, internal rotation was limited to 60 degrees, external rotation was limited to 50 degrees, abduction was limited to 110 degrees, and adduction was limited to 20 degrees. Nearly a year and a half later on 09/01/06, the employee still complained of 6/10 pain and burning in the neck and right shoulder region. Range of motion was still severely limited. Now, cervical spine flexion was limited to 40 degrees, extension limited to 34 degrees, left lateral flexion limited to 40 degrees, right lateral flexion limited to 32 degrees, left rotation limited to 70 degrees, and right rotation limited to 65 degrees. In comparison to the 06/30/05 records, there was some mild improvement. However, in comparison to the notes of 03/15/06, there was marked stability during this six month timeframe. Similar findings were noted in comparing the right shoulder range of motion results between 06/30/05, 03/15/06, and 09/01/06 evaluation dates. There was an apparent stability on 03/15/06 which was unchanged.

It appears that a chronic pain management program had been recommended by both Dr. and Dr. on multiple occasions. Then sometime around the beginning of the year 2007, the requests began changing to work hardening and then work conditioning.

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

The prior denial of twenty sessions of work conditioning had apparently been based on the ***Official Disability Guidelines*** and the Texas Labor Code documents mentioned in the Health Direct, Inc. preauthorization denial letters. The rebuttal letter provided by Spine & Rehabilitation suggests that the second denial by Direct, Inc. on 03/22/07 was in error when it cited a light duty physical demand capacity for the employee's current occupation, which apparently is listed more appropriately as a heavy duty capacity occupation.

Nevertheless, I still uphold the previous denial based on the following reasons.

This employee has undergone multiple surgeries to the cervical spine and one to the shoulder region. The employee has undergone a more than adequate amount of postoperative physical therapy treatments between June, 2005 and May, 2006. The employee had absolutely no cure or relief as indicated by the employee's stable pain levels of 6/10. The employee had absolutely no progress toward recovery as indicated by multiple repeat range of motion studies between March, 2006 and September, 2006. Finally, the employee has not been able to have any enhancement of employability.

Based on Texas Labor Code 408.021, the ongoing need for conservative physical therapy and/or rehabilitation services has not met medical necessity criteria.

The previous denial for the requested twenty sessions of work hardening is upheld. The basis for not allowing ongoing work condition at this point is based on the fact that previous trials of physical therapy both preoperatively and postoperatively have failed to provide any significant improvement, and therefore, one of the main entrance criteria for a work hardening and/or work conditioning program have not been met. Additionally, Texas Labor Code 408.021 suggests that medical necessity for ongoing conservative care is only appropriate if it meet three criteria which includes cure or relief, progress toward recovery, or enhancement of employability. These records clearly indicate that none of these criteria have been substantially reached.

If the IMED's decision is contrary to: (1) the DWC's policies or guidelines adopted under Labor Code §413.011, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of non-network health care or (2) the networks treatment guidelines, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

A. ***Official Disability Guidelines***
B. Texas Labor Codes