



DATE OF REVIEW: August 15, 2008

IRO Case #:

Description of the services in dispute:

Preauthorization - 10 days of work hardening.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Physical Medicine & Rehabilitation. This reviewer is a fellow of the American Academy of Physical Medicine and Rehabilitation and the American Academy of Neuromuscular and Electrodiagnostic Medicine. This reviewer is a member of the American Medical Association and the Physiatric Association of Spine, Sports, and Occupational Rehabilitation. This reviewer has been in active practice since 1996.

Review Outcome

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

Overtured

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Medical necessity does exist for the requested 10 days of work hardening.

Patient clinical history [summary]

Approximately 280 pages of medical records relative to this case have been reviewed, and this reviewer expressly accepts the objective findings of the examining physicians documented therein. Briefly, this case involves a XX-year-old female who was injured while working as an at onXX/XX/XX. According to the records, she slipped on an icy ladder and caught herself with her right arm, resulting in pain in her right arm, shoulder, neck, and head. She had x-rays performed of

the shoulder and neck, both of which were unremarkable. An MRI (magnetic resonance imaging) of the right shoulder demonstrated some supraspinatus tendinosis without evidence of tear. She was treated with injections and physical therapy without benefit, per the report. She had a behavioral health assessment on 4/11/08, which indicated that she had an adjustment disorder with mixed anxiety and depressed mood relative to her work injuries of cervical sprain/strain and right shoulder strain/sprain. Electrodiagnostic testing on 5/8/08 demonstrated no abnormalities in the

right upper extremity. She was seen on 5/15/08 by DO who noted that further PT (physical therapy) was denied, but opined that she would be an excellent candidate for a work hardening program. He recommended light duty with restrictions, a multidisciplinary return to work program, and an orthopedic consultation. evaluation on 6/10/08 indicated goals of a multidisciplinary work hardening program. This was to include physical and behavioral modalities as well as educational and process oriented group therapy with emphasis on relevant pain control techniques and strategies. This program was recommended for a minimum of 20–30 days. A functional abilities evaluation on 6/10/08 demonstrated significant functional loss of the right upper extremity. Some increased variance was documented as well suggesting inconsistent effort on that side. A report per the from 6/16/08 indicated that the injured worker would benefit from a 10 day work hardening trial with a goal of increasing her functional capacity such that she would be able to return to work. The request was denied by , given that the records did not reflect evidence of significant pathology as a result of the injury. The FCE (functional capacity evaluation) was not felt to be valid, given that grip and pinch strength were documented as being identical. Concern was expressed regarding the injured worker's true willingness and effort towards return to work. Orthopedic evaluation on 7/14/08 per , DO indicated no evidence of acute shoulder pathology and findings of scapular dysfunction and trigger points about the right shoulder. He recommended no restrictions, as well as scapulothoracic strengthening and stabilization. According to the records, she completed 12 sessions of PT from 11/28/07–5/21/08. A description of the injured worker's position as a grocery order filler indicates that she must be able to occasionally lift up to 60 pounds and regularly lift up to 50 pounds. Review of the records from the time of the injury include an ER (emergency room) report from 7/8/07 that indicated the worker injured her shoulder when reaching for supplies on a shelf. She was diagnosed with a shoulder strain and given a muscle relaxer and anti-inflammatory. An evaluation the following day by , MD indicated that the worker injured herself when she was reaching up. She slipped, and banged her arm on a shelf. Her exam indicated tenderness only to the AC (acromioclavicular) joint – no other shoulder or neck tenderness was noted. She was advised to return to work 7/10/07 with restrictions until 7/16/07. By the time of follow up evaluation on 8/11/07, she reported increased shoulder pain with radiation to the neck and reduced range of motion of the shoulder. An MRI (magnetic resonance imaging) was consequently ordered and demonstrated tendinosis. She was advised to continue working with restrictions for another 2 weeks. She received an injection on 8/20/07 with some improvement in her symptoms. She presented to the ER for increased right shoulder pain on 9/1/07 for which she received a Toradol injection. Orthopedics was subsequently consulted and recommended PT. By 11/8/07, she was not working (she had only been allowed 90 days of light duty) and still had not received PT. She was allowed to return to work with restrictions. The PT evaluation is documented for 11/28/07. Follow up at the occupational health clinic on 12/13/07 indicated no progress with therapies. Per the evaluation on 1/10/08, the worker was still having pain, and was not able to lift more than 30 pounds. She had apparently been employed as a prior to her position at . She was given another shoulder injection on that date with significant improvement documented by 1/17/08 with complete resolution of her shoulder pain, although she noted some numbness in her right arm

distally. She was felt to have had resolution of her tendinosis and that she would be ready for return to regular duty on 1/26/08. She then presented to the ER on 1/23/08 for an evaluation of increased right shoulder pain and headache, for which she was treated with Flexeril, Ultram, and advised to continue Naprosyn. This apparently developed after carrying a gallon of milk. Examination on 1/24/08 documented reduced shoulder range of motion with a normal neurological exam. The worker was felt to have exacerbated her tendinosis, and was advised to continue with

her medications, home exercises, ice, and modified activities. Subsequent evaluation on 1/31/08 indicated that the worker had also myofascial pain involving the right shoulder and neck. The worker indicated that she was hesitant to return to her former position of employment and consideration was being given toward lighter activities within the store.

Cervical spine films from

1/31/08 demonstrated mild reversal of the normal cervical lordosis without other abnormalities. She was subsequently evaluated at on 2/4/08 for her final assessment with an impairment determination that date as it was opined that she was at maximum medical improvement in regards to her injury. This report indicates that every time the worker would try to increase her activity

level, she would experience an exacerbation of her symptoms. She was noted to have good range of motion, but also had persistent regional tenderness about the right upper back and neck.

Based on her range of motion and the AMA Guides to the Evaluation of Permanent Impairment, 4th Edition, the evaluator (, MD) opined that she had a 0% impairment of her right shoulder relative to her supraspinatus tendinosis. He further indicated that he had discussed alternative employment positions within with the worker in order to avoid exacerbation of her shoulder symptoms.

According to the next office visit only a week later on 2/11/08, she returned to work as an order filler, and had an exacerbation of her symptoms. She was advised that she was experiencing a cumulative trauma disorder and that her current job was not a good fit for her. She indicated at the next visit on 2/22/08 that she was feeling better off work and that she had been advised that she could not seek a different position until she had worked her former position for a period of time.

She indicated that she wanted to try to return to that position and was advised to remain off work for another 4 weeks and then resume her work. It was noted that she did receive some benefit from

the fact that her husband was a massage therapist. She was subsequently apparently seen in the ER again on 3/12/08 for increased shoulder pain and advised to use a sling for 5 days. She was then evaluation by , DO on 3/21/08, and was advised to be off work for thirty days and undergo physical therapy and further workup. She was treated with Darvocet and Soma, as well. Further testing and consultations, as documented above, were unremarkable. She did receive a PT evaluation at the on 4/3/08. Subsequent PT note from 5/21/08 indicated that she had not received any therapy because of denials from her insurer. She was noted to have a significant degree of tenderness and spasm on her examination with reduced range of motion of the neck and right shoulder, and was documented to be unable to perform specific testing because of pain. She had a subsequent independent medical evaluation per MD. The documented examination was limited, but indicated that the worker had tenderness about her right shoulder with reduced range of motion. She opined that the worker was not yet at MMI, and recommended consultation with a shoulder specialist. Follow up with Dr. indicated that the worker continued with her no work

status, and that she remained symptomatic. She had a pain management appointment scheduled for 5/5/08. She was seen by MD on 5/5/08, who agreed with the requested cervical MRI that had been denied by workers' compensation and recommended Lidoderm patches for pain control. She received weekly psychotherapy evaluations from 5/9/08 through 6/18/08 without any documented improvement. The 6/18/08 note indicated the worker remained irritable and sad, and continued to report a pain level of 7/10. Initial pain level was 6/10. A request for reconsideration of the work hardening request was submitted on 7/1/08. This report indicates that the COV (coefficient of variance) was documented as less than 15%, which is not accurate for all measures. COV for lifting with the right upper extremity was 29%. The report states that there is no evidence that the worker would not put forth full effort in a work hardening program.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

This case involves a XX-year-old female employee of who injured her right shoulder and upper back while working as an . She has reported persistent pain in the right shoulder and right upper back since that time, with limited benefit from physical therapy and cortisone injections to the right shoulder. She has attempted to return to her former position of employment, which is in the medium work category, but has been unsuccessful due to exacerbation of her symptoms. No light duty work is available to her for the long term at . She cannot bid on a different job without completing a period of time at her current job. Her evaluations have documented pain and spasm in the right upper back with symptoms also consistent with regional myofascial pain. She has variable range of motion of the right shoulder and an MRI has demonstrated evidence of a supraspinatus tendinosis. Cervical spine films were reported as unremarkable, aside from mild reduction of the normal cervical lordosis. She has been evaluated by a number of physicians, most recently by an orthopedist who recommended no surgery, but instead suggested a program of scapulothoracic strengthening. She was seen on one occasion at pain management and given a prescription for Lidoderm patches. She had a functional capacity evaluation, which was limited by pain, and did demonstrate one COV of 29%. Other documented COVs were less than 15%. She is receiving counselling for adjustment disorder with depression and anxiety. A work hardening program has been requested.

It should be noted that the Official Disability Guidelines are supportive of a multidisciplinary work hardening program in such a case, provided that the injured worker participates fully and demonstrates progress within the first two weeks. The ODG indicates an appropriate course of treatment would be 10 sessions over the course of 8 weeks. While much of the patient's pain appears to be myofascial in nature, her record does indicate prior attempts at return to work with no work options otherwise. She is a year out from her injury. The ODG does support a multidisciplinary program within two years of the original injury.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Extensive medical record review

The Official Disability Guidelines

The Official Disability Guidelines – available online at www.odg-twc.com