I-Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JULY 10, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 Sessions of Work Hardening and 1 FCE:

97545 – 12 Units on 7/16/07, 7/17/07, 7/18/07, 7/19/07, 7/23/07, 7/24/07, 7/25/07, 7/27/07, 8/3/07, 8/8/07, 8/9/07, 8/10/07.
97546 – 64 Additional Units on 7/16/07, 7/17/07, 7/18/07, 7/19/07, 7/23/07, 7/24/07, 7/25/07, 7/27/07, 8/3/07, 8/8/07, 8/9/07, 8/10/07.
97750 – 8 Units on 8/14/07

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

AADEP Certified
Whole Person Certified
TWCC ADL Doctor
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Clinical practice 10+ years in Chiropractic WC WH Therapy

REVIEW OUTCOME

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

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.

97545	**12 Units**	**7/16/07, 7/17/07, 7/18/07, 7/19/07, 7/23/07, 7/24/07,**	***UPHELD***

		7/25/07, 7/27/07, 8/3/07, 8/8/07, 8/9/07, 8/10/07	
97546	**64 Units**	**7/16/07, 7/17/07, 7/18/07, 7/19/07, 7/23/07, 7/24/07, 7/25/07, 7/27/07, 8/3/07, 8/8/07, 8/9/07, 8/10/07**	***UPHELD***
97750	**8 Units**	**8/14/07**	***UPHELD***

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/28/07 and 4/15/08
ODG Guidelines and Treatment Guidelines
Rehab 2112, 5/23/08, 3/25/08, 6/8/07
Interim FCE, 8/14/07
6/26/07
Initial FCE, 7/12/07 (Amended 7/23/07)
xx Position, Description
Patient Orientation, 7/16/07
Impairment Rating, 7/12/07
Psy.D., 7/13/07
Stress and Lifestyle-Change Survey, 7/12/07
Injury Impact Questionnaire, 7/12/07
WC/WH Program Daily Notes, 8/14/07, 8/13/07, 8/10/07, 8/9/07, 8/8/07, 8/7/07, 8/6/07, 8/3/07, 8/2/07, 8/1/07, 7/31/07, 7/30/07, 7/27/07, 7/26/07, 7/25/07, 7/24/07, 7/23/07, 7/20/07, 7/19/07, 7/18/07, 7/17/07, 7/16/07
Chiropractic, Exams, 6/29/07, 6/28/07, 6/27/07, 6/26/07, 6/25/07, 6/22/07, 6/21/07, 6/20/07, 6/19/07, 6/18/07, 6/15/07, 6/14/07, 6/13/07, 6/12/07
Case Management Summaries, 8/14/07, 7/31/07, 7/24/07, 7/17/07
Psychology Group Notes, 7/31/07, 7/24/07, 7/17/07
MRI Scan of Left Wrist, 6/27/07
Dr. MD, 6/28/07
X-Ray, 6/12/07
MD, 8/1/07
Designated Doctor Examination, 8/1/07
MD, 7/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was involved in an occupational injury on xx/xx/xx. She was injured while performing repetitive duties as a xxxx . The injured employee developed bilateral carpal tunnel symptoms. The injured employee underwent an MRI, EMG/NCV, and FCE, and participated in a work hardening program. The patient was seen by a designated doctor who stated that the patient was not at MMI. A peer review was performed on 4-15-2008 and 8-28-2008 and work hardening was not recommended.

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

This injured worker does not meet the criteria for a work hardening program for the following reasons:

- There was no defined return to work goal agreed to by the employer & employee as indicated in ODG criteria #2.
- Treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains).
- Carpal tunnel syndrome seems to be primarily attributable to CTS-prone personal characteristics (e.g., obesity, diabetes, female, smoking).
- A recent study of wrist posture, loading and repetitive motion as risk factors for developing carpal tunnel syndrome, found that frequent flexion (OR 4.4), frequent extension (OR 2.7), and sustained forceful motion (OR 2.6) were associated with CTS, but neutral wrist position and repetitive wrist motion were not associated with CTS.
- Splitting, physical therapy, and fading of treatment frequency.
- No records of a complete psychological assessment.

Carpal tunnel syndrome seems to be primarily attributable to CTS-prone personal characteristics (e.g., obesity, diabetes, female, smoking), but symptoms may be associated with workplace activities. (Melhorn, 2008) (Lozano-Calderon, 2008) Some controversy continues about whether computer work is a risk factor for CTS, with current opinion that the keyboard is low risk and that the mouse may be mild risk. There is some evidence to conclude that CTS symptoms are associated with workplace activities, but current studies have not proven a causal relationship. (Nathan, 1993) (Lam, 1998) (Nordstrom, 1997) (Moore, 1997) (NIOSH, 1992) (Stevens-Mayo, 2001) (Denniston, 2001) (Andersen-JAMA, 2003) (WCB-Alberta, 2003) (Falkiner, 2002) (Nathan, 2002) (Dias, 2004) (Wellman, 2004) (You, 2004) (Boz, 2004) (Geoghegan, 2004) (Landau, 2005) (Bonfiglioli, 2006) (Melchior, 2006) (Derebery, 2006) (Werner, 2006) Microbreaks from repetitive motion jobs show positive, limited evidence. Limitations of keyboard work or pinch grasping may be a reasonable option during the first few weeks after onset of symptoms. There is evidence that keyboard users may experience a reduction in hand pain after several months of use of some alternative geometry keyboards, although the benefit appears to be user preference. Activities that aggravate symptoms include: (1) repetitive or prolonged wrist movement, especially if forceful (e.g., keyboarding, butchering, assembling, hammering, buffing, grinding, sanding, scrubbing, packing, sorting mail, wringing laundry, opening jars, knitting, turning a key, gripping a doorknob, playing a musical instrument, etc.); (2) localized mechanical stresses (e.g., prolonged pressure over the wrist or palm); (3) exposure to excessive vibration (e.g., a jackhammer, chainsaw); and (4) prolonged exposure to cold temperatures (e.g., handling cold parts). (Mclean, 2001) (Rempel, 1999) (Tittiranonda, 1999) Although obesity and gender are consistent predictors of CTS, workplace demands appear to bear an uncertain relationship to CTS. (Nathan, 2005) Regarding preplacement nerve testing for CTS, not hiring workers with abnormal post-offer preplacement median nerve tests to reduce costs of work-related CTS is not a cost-effective strategy for employers. (Franzblau, 2004) (Werner, 2006) And genetic testing is not recommended. (Schulte, 2003) High force with repetitive work was associated with a higher level of CTS and abnormal NCS. These findings appeared to be reversible following a period of less repetitive work. Prevalence of CTS was significantly higher in assembly line workers compared to non-assembly line workers. (Bonfiglioli, 2006) A recent study of wrist posture, loading and repetitive motion as risk factors for developing carpal tunnel syndrome, found that frequent flexion (OR 4.4), frequent extension (OR 2.7), and sustained forceful motion (OR 2.6) were associated with CTS, but neutral wrist position and repetitive wrist motion were not associated with CTS. (Fung, 2007) See also Return to work.

ODG Capabilities & Activity Modifications for Restricted Work:
Modified work: Repetitive motion activities limited to 4 hours or less per 8-hour day broken into periods of 1-hour regular activities and 1 hour of alternate activities, repeated for the workday. Avoidance of prolonged periods in wrist extreme flexion or extension.
Regular work (if not aggravating symptoms): Repetitive motion activities limited to 6 hours or less per 8-hour day broken into periods of 1-1/2 hour regular activities and 30 minutes of alternate activities, repeated for the workday. Avoidance of prolonged periods in wrist extreme flexion or extension.

Work conditioning, work hardening	Recommended as an option, depending on the availability of quality programs. Physical conditioning programs that include a cognitive-behavioral approach plus intensive physical training (specific to the job or not) that includes aerobic capacity, muscle strength and endurance, and coordination; are in some way work-related; and are given and supervised by a physical therapist or a multidisciplinary team, seem to be effective in reducing the number of sick days for some workers with chronic back pain, when compared to usual care. However, there is no evidence of their

	efficacy for acute back pain. These programs should only be utilized for select patients with substantially lower capabilities than their job requires. The best way to get an injured worker back to work is with a modified duty RTW program (see ODG Capabilities & Activity Modifications for Restricted Work), rather than a work conditioning program, but when an employer cannot provide this, a work conditioning program specific to the work goal may be helpful. (Schonstein-Cochrane, 2003) Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate in this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). (Lang, 2003) Work Conditioning should restore the client's physical capacity and function. Work Hardening should be work simulation and not just therapeutic exercise, plus there should also be psychological support. Work Hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work conditioning and work hardening are not intended for sequential use. They may be considered in the subacute stage when it appears that exercise therapy alone is not working and a biopsychosocial approach may be needed, but single discipline programs like work conditioning may be less likely to be effective than work hardening or interdisciplinary programs. (CARF, 2006) (Washington, 2006) Use of Functional Capacity Evaluations (FCE's) to evaluate return-to-work show mixed results. See the Fitness For Duty Chapter. **Criteria for admission to a Work Hardening Program:** 1. Physical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. 2. A defined return to work goal agreed to by the employer & employee: a. A documented specific job to return to with job demands that exceed abilities, OR b. Documented on-the-job training 3. The worker must be able to benefit from the program. Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program. 4. 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 may not benefit. 5. Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less. **ODG Physical Therapy Guidelines – Work Conditioning** 10 visits over 8 weeks See also Physical therapy for general PT guidelines.

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)**