

# US Decisions, Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW:** June 15, 2008

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

CPT Code 97750, 16 Units, on 6/26/2007  
CPT Code 97545, 2 Units, from 6/27/07 to 6/28/07  
CPT Code 97546, 12 Units, from 6/27/07 to 6/28/07  
CPT Code 97545, 2 Units, from 7/2/07 to 7/3/07  
CPT Code 97546, 12 Units, from 7/2/07 to 7/3/07  
CPT Code 97545, 1 Unit on 7/5/07  
CPT Code 97546, 6 Units, on 7/5/07  
CPT Code 97545, 1 Unit on 7/6/07  
CPT Code 97546, 4 Units, on 7/6/07  
CPT Code 97545, 1 Unit on 7/9/07  
CPT Code 97546, 6 Units, on 7/9/07  
CPT Code 97750, 4 Units, on 7/9/07  
CPT Code 97545, 1 Unit on 7/16/07  
CPT Code 97546, 6 Units, on 7/16/07  
CPT Code 97545, 3 Units, from 7/23/07 to 7/25/07  
CPT Code 97546, 18 Units, from 7/23/07 to 7/25/07  
CPT Code 97545, 1 Unit on 7/27/07  
CPT Code 97546, 6 Units, on 7/27/07  
CPT Code 97545, 1 Unit on 7/30/07  
CPT Code 97546, 6 Units, on 7/30/07  
CPT Code 97545, 1 Unit on 8/1/07  
CPT Code 97546, 6 Units, on 8/1/07  
CPT Code 90882, 1 Unit, on 8/1/07  
CPT Code 97545, 2 Units, from 8/9/07 to 8/10/07  
CPT Code 97546, 12 Units, from 8/9/07 to 8/10/07  
CPT Code 97545, 5 Units, from 8/13/07 to 8/17/07  
CPT Code 97546, 26 Units, from 8/13/07 to 8/17/07  
CPT Code 97750, 16 Units, on 8/14/07  
CPT Code 97545, 1 Unit on 8/20/07  
CPT Code 97546, 6 Units, on 8/20/07  
CPT Code 97545, 1 Unit on 8/22/07  
CPT Code 97546, 6 Units, on 8/22/07  
CPT Code 97545, 1 Unit on 8/24/07  
CPT Code 97546, 6 Units, on 8/24/07  
CPT Code 97545, 3 Units, from 8/27/07 to 8/29/07

CPT Code 97546, 14 Units, from 8/27/07 to 8/29/07  
 CPT Code 97750, 16 Units, on 8/29/07

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

M.D., Board Certified in Physical Medicine and Rehabilitation  
 Subspecialty Board Certified in Pain Management  
 Subspecialty Board Certified in Electrodiagnostic Medicine  
 Residency Training PMR and Orthopaedic Surgery

**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)

Date of Injury	Type of Review	Service Begin Date	Service End Date	Primary Diagnosis Code	Service Being Denied	Units of Service	Upheld/Overturned
	Retro	6/26/07	6/26/07	722.0	97750	16	Upheld
	Retro	6/27/07	6/28/07	722.0	97545	2	Upheld
	Retro	6/27/07	6/28/07	722.0	97546	12	Upheld
	Retro	7/2/07	7/3/07	722.0	97545	2	Upheld
	Retro	7/2/07	7/3/07	722.0	97546	12	Upheld
	Retro	7/5/07	7/5/07	722.0	97545	1	Upheld
	Retro	7/5/07	7/5/07	722.0	97546	6	Upheld
	Retro	7/6/07	7/6/07	722.0	97545	1	Upheld
	Retro	7/6/07	7/6/07	722.0	97546	4	Upheld
	Retro	7/9/07	7/9/07	722.0	97545	1	Upheld
	Retro	7/9/07	7/9/07	722.0	97546	6	Upheld
	Retro	7/9/07	7/9/07	722.0	97750	4	Upheld
	Retro	7/16/07	7/16/07	722.0	97545	1	Upheld
	Retro	7/16/07	7/16/07	722.0	97546	6	Upheld
	Retro	7/23/07	7/25/07	722.0	97545	3	Upheld
	Retro	7/23/07	7/25/07	722.0	97546	18	Upheld
	Retro	7/27/07	7/27/07	722.0	97545	1	Upheld
	Retro	7/27/07	7/27/07	722.0	97546	6	Upheld
	Retro	7/30/07	7/30/07	722.0	97545	1	Upheld
	Retro	7/30/07	7/30/07	722.0	97546	6	Upheld
	Retro	8/1/07	8/1/07	722.0	97545	1	Upheld
	Retro	8/1/07	8/1/07	722.0	97546	6	Upheld
	Retro	8/1/07	8/1/07	722.0	90882	1	Upheld

	Retro	8/9/07	8/10/07	722.0	97545	2	Upheld
	Retro	8/9/07	8/10/07	722.0	97546	12	Upheld
	Retro	8/13/07	8/17/07	722.0	97545	5	Upheld
	Retro	8/13/07	8/17/07	722.0	97546	26	Upheld
	Retro	8/14/07	8/14/07	722.0	97750	16	Upheld
	Retro	8/20/07	8/20/07	722.0	97545	1	Upheld
	Retro	8/20/07	8/20/07	722.0	97546	6	Upheld
	Retro	8/22/07	8/22/07	722.0	97545	1	Upheld
	Retro	8/22/07	8/22/07	722.0	97546	6	Upheld
	Retro	8/24/07	8/24/07	722.0	97545	1	Upheld
	Retro	8/24/07	8/24/07	722.0	97546	6	Upheld
	Retro	8/27/07	8/29/07	722.0	97545	3	Upheld
	Retro	8/27/07	8/29/07	722.0	97546	14	Upheld
	Retro	8/29/07	8/29/07	722.0	97750	16	Upheld

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a man who reportedly was injured on xx/xx/xx when he felt a pop and pain in his left shoulder while rolling 200-300 pound drums. The FCE described the injury when pulling a 100 pound hydraulic lift. He complained of left shoulder pain on movement, especially abduction and pain down the left arm. The pain was described as a constant ache worse with lifting, pulling and driving. He also had paresthesias in the left fourth and fifth digits, sometimes the third digit. These appear to have developed after the initial assessment. These symptoms reportedly worsened with cervical flexion. He was described by Dr. on 8/31 as having pain on turning a key. He had postural dizziness attributed to a peripheral problem. This was aggravated with cervical extension.

He reportedly had no improvement after a series of shoulder corticosteroid injections and cervical epidural injections. He had consultations with two different orthopedic surgeons. One felt the problem was due to a brachial plexus upper and lower trunk injury with a partial rotator cuff tear, and the other felt the problem was related to cervical spondylosis at C6-7 and C7-T1.

No treating physician advised surgery, yet the 6/1/07 note for the impairment rating stated that this man felt that the orthopedic surgeon felt surgery on the shoulder may be necessary.

He had transient relief with shoulder injections and with cervical epidural injections, but some of the notes described worsening of the pain with the injections.

After the work hardening program, he entered a pain program. The last note dated 1/26/08 from Dr. showed . his pain improved to a 6 from an 8. He still had left shoulder pain that was worsened by testing. He was described with shoulder impingement syndrome. The Pain Clinic Discharge Summary (2/12/08) by Dr. reports he made improvement, but would have made more if additional treatment was authorized. He is now a painter, but can not lift paint buckets.

Dr. felt he was at MMI on 12/20/07 with an 11% impairment.

He had the following diagnostic studies:

2/2/06 MRI of the left shoulder showed tendinosis without tear in the supraspinatus, a normal rotator cuff, a type II acromion, and arthritis in the ac joint.

2/15/06 xrays of the cervical, lumbar spine and left shoulder

3/16//06 MRI of the cervical spine showed loss of the cervical lordosis, and narrowing of the C5-6 and C6-7 disc spaces, but no disc herniations or nerve compressions were described in the MRI report.

9/26/06 reportedly he had a CT myelogram that showed left C5/6/7 narrowing plus some possible calcification along the anterior cord. There was no description of any nerve root compression. The specific report was not provided, but comments were in the medical record.

10/10/06 ENG peripheral vestibular problem.

2/28/06 An EMG was done that was consistent with CTS. No evidence of any ulnar nerve compression was found. The study was done 13 days post injury. It was noted that a radiculopathy may take 3 or more weeks to be found on electrodiagnostic studies.

9/26/06 EMG reportedly showed a left C6 radiculopathy and ulnar nerve compression at the elbow. There was some abnormality in the first dorsal interosseoous muscle, and polyphasic potentials in all the muscles examined. The quality of the copy of this report made it difficult to read. The conclusion was legible.

A test by Dr. suggested a upper and lower branch injury of the brachial plexus. No testing results or reports were provided.

He reportedly had depression and anxiety.

He had multiple FCEs. He was reportedly not able to perform his work and his employer would not take him back with any restrictions. The FCEs reported that he was able to function at a medium level of function (PDL) which met those associated with his job description requirements of light to medium level of physical demand from some of the prior reviewers, vs. heavy demands per the job determination in the FCE reports.

He had a series of FCEs performed in 2007 on 5/24, 6/26, 7/6, 8/14 and 8/29. The initial one in May was repeated a month later without any intervening treatment. The functional level of his job description was that of truck driver helper with possible return to the job. He would need to occasionally lift 75-100 pounds, and frequently lift up to 50 pounds as described by the employee.

He had 16 sessions of work hardening from 6/28-8/29 (97545/ 97546) that are also under dispute. Sessions ranged from 5-8 hours. The latter was more common. The therapists described improvement of his pain from a 9 to an 8 during this time frame. His strength was initially reported as being poor, but improved to fair. His pain was only a 7 at the time of the first FCE in May 2007.

He had hourly psychotherapy associated with the work hardening. The Owestry and Neck Disability scores described severe perceived disability. His McGill Pain Questionnaire suggested possible pain exaggeration. He had depression and anxiety on the BECK studies.

Dr. felt he was not at MMI when seen in February and June 2007. He felt he had a cervical radiculopathy and rotator cuff tear based on the information at hand.

Dr. the Designated Doctor felt he had a shoulder injury and cervical strain. He was finally at MMI in December 2007 with an 11% rating. He had 5% from the cervical DRE II category and 6% for the shoulder.

Dr. said he had a cervical radiculopathy and vertigo. He noted symptoms increased after

the two FCEs that were in close proximity with each other.

Dr. on 9/9/06 felt low grade partial thickness rotator cuff and brachial plexus injury.

Dr. found that neck flexion increased left arm symptoms and extension gave dizziness. He felt that the exam suggested a possible C6/7 radiculopathy, but found no focal findings.

Dr. performed a peer review in March 2006. He felt the man had a shoulder strain. He felt that this man should have been at MMI and at work, but deferred due to limitations from illegible records.

Dr. performed an RME on 7/21/06 and could not determine the injury. He felt the problems were related to the neck and shoulder.

Dr. felt the problem was preexisting and related to degenerative changes in the neck and the shoulder (impingement). 6/10/07

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

This patient has subjective sensory complaints in the hand, but the reviewer did not find more than a general comment of motor loss. The MRI and CT myelogram did not objectively show any nerve root compression or disc herniations. There was only tendinosis in the shoulder MRI and normal rotator cuff. The medical records document possible impingement of the left shoulder.

Medical Necessity for FCEs: This patient's impingement problem was not improving, and in fact, he complained of increased symptoms with the FCEs. The first FCE, in May, was at the request of the Designated Doctor as well as Dr. This FCE is not in dispute as part of this review, however. There was no medical necessity for a repeat FCE a month later in the absence of any intervening treatment. Further, a third FCE in July was performed fewer than 2 weeks later. This was followed by two more in August. During this time, the therapists were monitoring the patient's participation and progress. It would appear from their notes that they did not feel he made much progress. The reviewer finds there is not medical necessity for the FCEs that are in dispute as part of this review.

Medical Necessity for Work Hardening Program: In order to meet the criteria to demonstrate medical necessity for the work hardening services that are in dispute the patient's job requirements would have to be clearly documented. However, this was not the case. The peer reviewers noted the need for medium level of function. There is no specific job description from the employer. It is noted that the employer would not accept this man back to work with any restrictions. The self description of work needs was provided by the patient. The treating therapists and Dr. said the patient's job description was at a heavy level.

A key point in the ODG guidelines is that work hardening program should restore function. This was not possible in this patient's case, as the program aggravated the condition according to the records. One peer reviewer felt surgery was appropriate based on the lack of clinical improvement and limited success with the local steroid injection. The orthopedic surgeon did not feel that this man was a surgical candidate for the shoulder. The need for surgery was determined as inappropriate by the consulting orthopedic surgeon, but felt necessary in lieu of work hardening by a peer reviewer. The multiple psychology sessions are tied into work hardening. He had some documented depression, but most of the treatment was apparently necessitated by the

## Work Hardening Protocol.

The lack of the clarification of the job demands, the excessive number of FCEs and the aggravation of symptoms warrant an adverse decision. The ODG Guidelines specify that “the worker must be able to benefit from the program.” Upon independent review of the provided medical records and ODG Guidelines, the reviewer finds no medical necessity for the following:

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CPT Code 97545, 2 Units, from 7/2/07 to 7/3/07  
CPT Code 97546, 12 Units, from 7/2/07 to 7/3/07  
CPT Code 97545, 1 Unit on 7/5/07  
CPT Code 97546, 6 Units, on 7/5/07  
CPT Code 97545, 1 Unit on 7/6/07  
CPT Code 97546, 4 Units, on 7/6/07  
CPT Code 97545, 1 Unit on 7/9/07  
CPT Code 97546, 6 Units, on 7/9/07  
CPT Code 97750, 4 Units, on 7/9/07  
CPT Code 97545, 1 Unit on 7/16/07  
CPT Code 97546, 6 Units, on 7/16/07  
CPT Code 97545, 3 Units, from 7/23/07 to 7/25/07  
CPT Code 97546, 18 Units, from 7/23/07 to 7/25/07  
CPT Code 97545, 1 Unit on 7/27/07  
CPT Code 97546, 6 Units, on 7/27/07  
CPT Code 97545, 1 Unit on 7/30/07  
CPT Code 97546, 6 Units, on 7/30/07  
CPT Code 97545, 1 Unit on 8/1/07  
CPT Code 97546, 6 Units, on 8/1/07  
CPT Code 90882, 1 Unit, on 8/1/07  
CPT Code 97545, 2 Units, from 8/9/07 to 8/10/07  
CPT Code 97546, 12 Units, from 8/9/07 to 8/10/07  
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CPT Code 97545, 1 Unit on 8/22/07  
CPT Code 97546, 6 Units, on 8/22/07  
CPT Code 97545, 1 Unit on 8/24/07  
CPT Code 97546, 6 Units, on 8/24/07  
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CPT Code 97750, 16 Units, on 8/29/07

From the ODG (the emphasis is mine):

**Recommended as an option**, depending on the availability of quality programs, and should be specific for the job individual is going to return to. ([Schonstein-Cochrane, 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.  
(CARF, 2006) (Washington, 2006)

**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, 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

**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)**