



Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 8/10/2009  
**IRO CASE #:**

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

Work hardening, 5 times per week for 2 weeks

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer graduated from and completed training in Chiropractor at. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Chiropractor since 1986 and currently resides in.

**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) Work hardening, 5 times per week for 2 weeks Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured employee is a xx year old male who presents with complaints of bilateral hand pain/numbness. The notes indicate the injured employee has carpal tunnel syndrome bilateral and arthritis of wrist bilateral and deQuervain's tenosynovitis bilateral.

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

The injured employee is a xx year-old male with a date of injury of xx/xx/xx as a . He had been employed by for 6 and ½ years at the time of his injury. His job duties included running winder machines and lifting and carrying fiberglass materials for cars and boats. He had been working 48 hours per week at the time the injury occurred. He reported that he was lifting material off a carrier when his hands began to hurt "real bad". Since at least September of 2007, the patient was under the care of orthopedic surgeon, , MD, for complaints of constant bilateral hand/wrist pain with numbness in thumbs, index, long, and ring fingers and the dorsum of the hands. He was diagnosed with bilateral degenerative joint disease of the basilar joint of the thumbs, bilateral carpal tunnel syndrome, and bilateral de Quervain's tenosynovitis. He was placed on modified duty. On 11/26/07 he had left carpal tunnel release and arthroscopic resection of the trapezium at the basilar joint of the left thumb. On 2/2/08 he had right carpal tunnel release and arthroscopic resection of the trapezium at the basilar joint of the right thumb. During follow-up visits with Dr. from September to November of 2008, the patient complained of bilateral hand pain and numbness and difficulty with stability and control. Diagnoses were bilateral carpal tunnel syndrome (resolved), arthritis of the bilateral wrists, bilateral de Quervain's tenosynovitis, and possible CRPS (RSD). A steroid injection was given, and further recommended treatment included bilateral dorsal compartment release, fusion of the wrists if pain was sufficient, possible TJA of the right carpometacarpal joint if resection arthroplasty was painful. Medications during that time have included Naprsoyn, Neurontin, Cymbalta, and Arthrotec.

He had a Designated Doctor Evaluation on 1/30/09 with orthopedic surgeon, , MD. The patient reported no relief since his 2 surgeries, in fact he felt worse. Examination revealed no atrophy of the upper extremities, weakness of left hand grip, weakness of right pinch strength, right greater than left range of motion restrictions in wrist extension, flexion and ulnar deviation. No evidence of CRPS was found, in that he had no vasomotor signs like mottling or cyanosis, no overly cool, dry, or moist skin, no frank edema, no trophic changes in skin texture, and no hair growth changes. Diagnoses were basilar arthritis of each thumb, bilateral carpal tunnel syndrome and bilateral extensor

tenosynovitis. He was not felt to be at maximum medical improvement at that time. Dr felt that the basilar joints at both thumbs had not been adequately treated, in that the usual standard of care was inter-positional arthroplasty which he did not undergo, and it was recommended that he be seen by an orthopedic hand specialist. It was also recommended that he see a neurologist and have a repeat EMG/NCV to further investigate carpal tunnel syndrome. He was to be re-evaluated by Dr in June 2009. EMG/NCV was performed by , MD on 6/3/09 and showed a focal conduction abnormality of the median nerve at the right wrist consistent with mild carpal tunnel syndrome.

The patient changed his treating doctor to , DC on 4/7/09. He complained of constant 8/10 right wrist pain, constant 7/10 left wrist pain, frequent 7/10 pins and needles in the right hand, and frequent 6/10 numbness in the left hand. Examination revealed hyperesthesia of the left C6 and right C6 and C7 dermatomes, pain in the right greater left hand/wrist during Tinel's, Phalen's and reverse Phalen's tests, restrictions in all bilateral wrist ranges of motion with right greater than left deficits, trigger points in the right wrist flexor group, moderate spasm and mild edema in the right extensor group, moderate spasm and moderate edema in the right flexor group, moderate spasm and mild edema in the left flexor group. He was totally temporarily precluded from regular work duties. Treatment plan was stated to be pending an orthopedic consult. It is unclear if that consult ever occurred as there is no report available. The patient was treated from 5/12/09 through 6/8/09 with 9 sessions of physical therapy, consisting of therapeutic exercises, massage, and paraffin baths.

A Mental Health Evaluation was performed on 5/6/09 by , Ph.D. Psychosocial stressors were identified primarily as frustration with his pain, anxiety, loss of income, fear of re-injury, and concern about his future employment. He was diagnosed with Generalized Anxiety Disorder and Pain Disorder associated with his General Medical Condition. Six individual psychotherapy sessions were completed. An FCE was performed on 6/10/09. His lift and carry tasks showed that he was functioning at a light-medium capacity when his job requirements as a for were heavy. He also demonstrated significant deficits in bilateral wrist flexion and extension with modest deficits in bilateral ulnar and radial deviation, all with severe pain; severe pain during active ranges of motion of all 5 digits of both hands; 3/5 weakness in wrist, thumb and hand muscle testing; significant strength loss below the normal population in all pinch strength tests in both hands.

A Work Hardening Program of 5 times per week for 2 weeks was recommended. This request was previously denied and upheld on appeal. Dr has submitted another request in which he states that the "patient is working with

at DARS, who is assisting the patient in entering a job training program, since he will not be able to return to a job similar to what he was doing". However, there is no documentation of what occupation he will train for, or that this occupation would have job demands that exceed his current abilities. Given the entirety of the information noted above in the referenced medical records, that this patient will not be able to return to a job that will require heavy manual labor with his hands even after work hardening, and that job training will necessarily need to focus on a sedentary or light occupation.. Therefore, his current level of function at a light-medium capacity precludes the medical necessity for the requested work hardening program. It has also been suggested that he may be a candidate for further surgery on his hands, which also precludes a work hardening program at this time. The injured employee does not meet ODG Criteria #3, 5, and 6 for Work Hardening.

Criteria for admission to a Work Hardening Program:

(1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA).

(2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning.

(3) Not a candidate where surgery or other treatments would clearly be warranted to improve function.

(4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.

(5) 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

(6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with 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.

(7) 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.

(8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less.

(9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities.

(10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

**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

**X** 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)