



Medical Review Institute of America, Inc.
America's External Review Network

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 in General Physical Medicine & Rehabilitation and Pain Medicine. This reviewer has been in active practice since 2005.

Review Outcome

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

Upheld

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 not exist for the requested 10 days of work hardening.

Information provided to the IRO for review

Records Received From :

Letter from , 7/29/08, 1 page

Fax cover sheet from , 7/29/08, 2 pages

Letter from , 8/5/08, 1 page

Confirmation of receipt of a request for a review by an independent review organization, 7/25/08, 4 pages

Request for review by an independent review organization, 7/24/08, 3 pages

Review determination, 6/23/08, 2 pages

Review determination, 7/7/08, 2 pages

Records Received From :

Notice of assignment of independent review organization, 7/29/08, 1 page

Request for a review by an independent review organization, 7/24/08, 3 pages

Preauthorization request, 6/16/08, 1 page

MRI report, 8/13/07, 2 pages

X-ray report, 9/27/07, 1 page
MRI report, 8/13/07, 2 pages
X-ray report, 1/31/08, 1 page
Initial behavioral medicine consultation, 4/11/08, 6 pages
Nerve conduction study, 5/1/08, 2 pages
Electrodiagnostic results, 5/1/08, 2 pages
History and physical, 5/15/08, 3 pages
Multidisciplinary work hardening plan and goals of treatment, 7/8/07, 4 pages
Functional abilities evaluation, 7/8/07, 13 pages
Work hardening program preauthorization request, 6/16/08, 3 pages
Review determination, 6/23/08, 2 pages
Environmental intervention, 6/24/08, 1 page
Initial evaluation, 7/14/08, 2 pages

Records Received From URA:

Letter from , 7/30/08, 1 page
Confirmation of receipt of request for a review by an independent review organization, 7/25/08, 7 pages
Review determination, 6/23/08, 2 pages
Review determination, 7/7/08, 2 pages
Independent review organization summary, 7/8/04, 2 pages
Employer's first report of illness or injury xx/xx/xx, 1 page
Associate statement, xx/xx/xx, 2 pages
Job description, 6/5/08, 2 pages
Workers Compensation request for medical care, xx/xx/xx, 1 page
Patient note, xx/xx/xx, 2 pages
Emergency department note, xx/xx/xx, 1 page
Prescriptions, 7/9/07, 1 page
Patient note, 7/9/07, 1 page
Patient notes, 7/9/07, 4 pages
Texas Workers Compensation work status report, 7/9/07, 2 pages
Texas Workers Compensation work status report, 7/17/07, 1 page
Patient notes, 8/6/07, 3 pages
Emergency department note, 8/11/07, 2 pages
Patient notes, 9/25/07, 4 pages
MRI report, 8/13/07, 2 pages
MRI report, 8/13/07, 2 pages
Texas Workers' Compensation work status report, 8/6/07, 1 page
Patient notes, 9/24/07, 5 pages
Texas Workers Compensation work status report, 8/20/07, 1 page
Patient note, 8/27/07, 3 pages
Texas Workers Compensation work status report, 8/27/07, 1 page
Emergency physician record, 9/1/07, 3 pages
Texas Workers Compensation work status report, 9/11/07, 1 page

Patient notes, 9/5/07, 3 pages
Texas Workers Compensation work status report, 9/27/07, 1 page
Patient notes, 9/27/07, 3 pages
Radiology report, 9/27/07, 1 page
Texas Workers Compensation work status report, 11/5/07, 1 page
Patient notes, 11/5/07, 4 pages
Initial evaluation, 11/28/07, 4 pages
Plan of care, 11/28/07, 3 pages
Daily notes, 12/5/07, 2 pages
Texas Workers Compensation work status report, 12/13/07, 1 page
Patient notes, 12/13/07, 3 pages
Re-evaluation, 7/8/07, 4 pages
Texas Workers Compensation work status report, 1/10/08, 1 page
Patient notes, 1/10/08, 2 pages
Texas Workers Compensation work status report, 1/17/08, 1 page
Patient notes, 1/17/08, 2 pages
Emergency physician record, 1/23/08, 4 pages
Emergency room records, 1/23/08, 15 pages
Patient notes, 1/24/08, 4 pages
Texas Workers Compensation work status report, 1/31/08, 1 page
Patient notes, 1/31/08, 3 pages
Radiology report, 1/31/08, 1 page
Report of medical evaluation, 2/8/08, 1 page
Texas Workers Compensation work status report, 2/11/08, 1 page
Work related injury report, 2/8/08, 4 pages
Texas Workers Compensation work status report, 2/11/08, 1 page
Patient notes, 2/11/08, 2 page
Texas Workers Compensation work status report, 2/19/08, 1 page
Patient notes, 2/18/08, 3 pages
Work status form, 3/12/08, 1 page
History and physical, 3/21/08, 3 pages
Texas Workers Compensation work status report, 3/26/08, 1 page
History and physical, 3/26/08, 3 pages
Physical therapy evaluation, 4/8/08, 3 pages
Initial behavioral medicine consultation, 4/11/08, 6 pages
Report of medical evaluation, 4/15/08, 1 page
Designated doctor evaluation, 4/15/08, 3 page
Environmental intervention, 7/8/07, 3 pages
Texas Workers Compensation work status report, 4/24/08, 1 page
Nerve conduction study, 7/8/07, 2 pages
Electrodiagnostic results, 5/1/08, 2 pages
New patient office note, 5/5/08, 3 pages
Lab report, 5/7/08, 3 pages
Physician testing selection standing order, 10/18/07, 1 page

Lab report, 5/5/08, 1 page
Psychotherapy note, 5/9/08, 1 page
Psychotherapy note, 5/15/08, 1 page
Texas Workers Compensation work status report, 5/15/08, 1 page
History and physical, 5/15/08, 3 pages
Patient notes, 5/21/08, 1 page
Psychotherapy note, 5/22/08, 1 page
Psychotherapy note, 6/3/08, 1 page
Multidisciplinary work hardening plan and goals of treatment, 6/10/08, 3 pages
Initial functional capacity test, 6/10/08, 2 pages
Functional abilities evaluation, 7/8/07, 13 pages
Evaluation and reassessment note, 6/10/08, 1 page
Psychotherapy note, 6/11/08, 1 page
Job description/employer contact form, 6/12/08, 2 pages
Work hardening program preauthorization request, 6/16/08, 4 pages
Fax from 6/17/08, 1 page
Psychotherapy note, 6/18/08, 1 page
Treatment summary/reassessment, 6/18/08, 2 pages
Texas Workers Compensation work status report, 6/26/08, 1 page
Follow up note, 6/26/08, 1 page
Fax to , 7/1/08, 1 page
Reconsideration work hardening preauthorization request, 7/1/08, 4 pages
Texas Workers Compensation work status report, 7/24/08, 1 page
Notice of assignment of independent review organization, 7/29/08, 1 page
Fax to , 7/24/08, 1 page
Fax to 7/29/08, 1 page
Fax to , 6/17/08, 1 page
Fax to , 7/24/08, 1 page
Note from , undated, 1 page
Fax to TDI-HWCN, 7/25/08, 1 page
Check copy, 7/31/08, 1 page

Patient clinical history [summary]

The patient is a xx-year-old female whose date of injury is listed as xx/xx/xx. On this date the patient was working as an at climbing on a ladder and reaching for an object. It was reportedly icy and the patient slipped. To avoid falling she suspended her weight with her right arm hanging from a height. The patient reports that she felt a pop in the shoulder and pain into the shoulder area. The patient also reports pain in the right side of her lower neck and intermittent numbness and tingling in her forearm and hands since the date of injury. The patient was seen by , PA-C, and it was felt that the patient had a right shoulder strain. The patient was treated symptomatically with modified duty, ice, moist heat, muscle relaxants and anti-inflammatory medications. The patient underwent a subacromial injection in August 2007, which reportedly did not help much. The patient underwent an MRI of the right shoulder on 08/13/07, which revealed supraspinatus tendinosis and a subcoracoid ganglion cyst; the tendons of the rotator cuff were intact. The patient

continued with significant pain in the shoulder area and was referred to Dr. on 09/27/07. The patient was recommended to undergo physical therapy and strengthening exercises. Three views of the right shoulder performed on 09/27/07 revealed no evidence of an acute process. An initial evaluation dated 11/28/07 reports that the patient is unable to work secondary to dysfunction. It is reported that the patient exhibits mild atypical pain behavior in response to therapeutic activity performed during the visit. The patient was recommended for rehabilitative therapy in conjunction with a home exercise program. A follow up note dated 12/13/07 indicates that the patient was returned to modified duties with an estimated date to full duties of 6 weeks and estimated MMI in 6 weeks. A reevaluation note dated 01/04/08 indicates that right shoulder range of motion is within normal limits. The patient subsequently underwent an injection of the supraspinatus tendon on 01/10/08 and had excellent results. The patient was seen on 01/17/08 and reported that her pain had resolved in the shoulder and she had no difficulties with movement. The patient subsequently began having increasing pain secondary to lifting heavy objects. Each time the patient began lifting and returning to activity, she reported increasing discomfort in the shoulder and neck area. The patient underwent cervical spine radiographs on 01/31/08, which revealed no acute abnormality. A follow up note dated 01/31/08 indicates that the patient has returned to work full duty and exacerbated her right supraspinatus tendinosis while carrying a gallon of milk and was seen in a local emergency room. The patient was given oral medications and released.

An occupational medicine note and impairment rating dated 02/08/08 indicates that after the patient's date of injury she continued to have pain in the right shoulder with pain extending into the right upper back. The pain resolved with rest. There is no neck pain and no radiation of pain. The patient continues to have good range of motion with significant tenderness to palpation along the entire right side of the neck, trapezius, and supraspinatus muscle group. This is reportedly a final evaluation and case closure. The patient reports that Tramadol is quite helpful and when she takes it she has no significant distress. On physical examination the patient's passive range of motion shows no crepitation, clunking or intrinsic tightness of the shoulder. Strength against resistance reveals minor discomfort in the shoulder above shoulder level. Rotator cuff strength testing is intact. Neurologic status is normal with good deep tendon reflexes and grip strength is intact. Right shoulder range of motion is reported as flexion of 180 degrees, extension 50 degrees, abduction 107 and adduction 40, internal rotation 80 and external rotation 90. The patient was placed at maximum medical improvement as of 02/08/08 and given a 0% whole person impairment rating.

Follow up note dated 02/11/08 indicates that the patient was allowed to return to work with no restrictions or accommodations, though she was advised to try to transfer to another position that did not require as much heavy lifting. Each time the patient attempts to return to her job she reports increasing difficulty with pain. The patient was subsequently placed on modified duty. The patient was advised by her employer to remain at home until she is off all restrictions as there is no light duty work available. The patient will be seen in follow up in 4 weeks and "most likely at that time we can discontinue her restrictions".

The patient underwent initial behavioral medicine consultation on 04/11/08. The patient rated her pain as 8/10. The patient endorses sleep maintenance insomnia and reports difficulty with certain

ADLs such as self-grooming, household chores and caring for her children. BDI was reported as 41 and BAI was 24. The patient was diagnosed with adjustment disorder with mixed anxiety and depressed mood secondary to the work injury. The patient was recommended for cognitive behavioral therapy.

The patient underwent designated doctor evaluation by Dr. on 04/15/08. The patient was found not to have reached MMI at this time, with an expected MMI date of November 2008.

The patient subsequently underwent 6 sessions of individual psychotherapy for diagnosis of adjustment disorder. After 6 sessions the patient's pain level had increased from 6/10 to 7/10. Irritability and frustration increased from 4 to 8. Muscle tension, nervousness and sadness increased from 5 to 7. The patient reports emotionally feeling calmer. The patient's BDI improved from 41 to 28 and BAI improved from 24 to 23.

The patient underwent EMG/NCV of the right upper extremity on 05/01/08, which was reported as a normal study with no electrodiagnostic evidence of neuropathy in relation to plexopathy, polyneuropathy, mononeuropathy and/or primary muscle disease.

The patient was seen on 05/05/08 by Dr. . On physical examination the patient has decreased cervical flexion secondary to pain with less pain on extension. There is tenderness to palpation in the lower cervical area on the right. The patient has good range of motion of the shoulder. DTRs are 2+ bilaterally. The patient was recommended to undergo additional diagnostic testing and given Lidoderm patches.

A history and physical for work hardening was performed by Dr. on 05/15/08. The patient has reportedly had ineffective physical therapy and would be an excellent candidate for work hardening. On physical examination the patient has paravertebral spasms and tenderness in the cervical lumbar spine. There is decreased range of motion of the cervical spine with cervical myospasm and myositis. Deep tendon reflexes are decreased in the right upper extremity. The patient has decreased range of motion of the right shoulder. Diagnoses are listed as cervical sprain/strain, right shoulder sprain/strain, internal derangement of the right shoulder, right rotator cuff tear, cervical herniated discs at C5-6 and C6-7, right cervical radiculopathy. The patient was placed on light duty with restrictions and medically cleared for work hardening.

A functional abilities evaluation performed on 06/10/08 indicates that the patient's pain level is 8/10. Cervical range of motion was listed as flexion 20% of normal, extension 74% of normal, left lateral flexion 50% of normal, right lateral flexion 53% of normal, left rotation 38% of normal, and 50% of normal. Right shoulder range of motion was noted as flexion 53% of normal, extension 50% of normal, abduction 49% of normal, adduction 0% of normal, internal rotation 6% of normal, and external rotation 39% of normal. The patient was reportedly capable of performing at the sedentary physical demand level and she is required to work at a medium to medium-heavy level.

A work hardening program preauthorization request dated 06/16/08 indicates that the patient listed her medications as Darvocet, Soma and Lidoderm patches. All active symptoms have

reportedly been reduced with prior treatment, and her treatment team is happy with her progress. The patient reportedly still has obvious psychological overlay that requires a multidisciplinary approach. The patient has reportedly shown significant improvement and has reached a plateau in active exercises. The request was denied on utilization review on 06/23/08 noting that "the recent FCE is not a valid starting point" and that work hardening would not be approved without some evidence of effort on evaluation used to monitor progress. There is reportedly a lack of reasonable expectation that the patient's goals can be attained, and there is no expectation of improved function based on the submitted records. Reconsideration request dated 07/01/08 reports that the FCE is valid and there is no evidence that the patient is putting forth submaximal effort. It is noted that all members of the patient's treatment team have recommended work hardening.

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

The request for 10 sessions of work hardening is not recommended as medically necessary. The patient sustained an injury on 07/08/07 as a result of a fall at work and was subsequently diagnosed with a right shoulder strain. An evaluation dated 11/28/07 noted that the patient demonstrated mild atypical pain behavior during therapeutic activity. A follow up note dated 12/13/07 indicates that the patient was returned to work on modified duty, with an estimated date to full duties and maximum medical improvement in 6 weeks. The patient underwent physical therapy and injections with the second injection performed on 01/10/08 reportedly providing "excellent results". On 01/17/08 the patient reported that her shoulder pain had resolved and that she had no difficulties with movement. Radiographs of the cervical spine were unremarkable, and MRI of the right shoulder revealed only supraspinatus tendinosis. The patient was returned to full duty work in January 2008, and it is reported that the patient exacerbated her right shoulder pain while carrying a gallon of milk. It is reported that every time the patient returned to work and began lifting, her shoulder pain increased. An impairment rating on 02/08/08 reported that the patient's pain resolved with rest, and that there is no neck pain and no radiation of pain. The patient was found to be at maximum medical improvement as of that date with a 0% whole person impairment rating. The patient was again returned to full duty work per a note dated 02/11/08 and advised to transfer to a position with less heavy lifting. The patient was subsequently placed on modified duty; however, there was no light duty work available. The patient was subsequently diagnosed with adjustment disorder and underwent 6 sessions of individual psychotherapy. Per the final individual psychotherapy note the patient's subjective pain level increased, irritability and frustration increased and muscle tension, nervousness and sadness had increased. A designated doctor on 04/15/08 found that the patient had not reached MMI with an expected MMI date of November 2008. Serial physical examinations note that the patient has full range of motion of the shoulder; however, functional abilities evaluation performed in June 2008 reported severely restricted range of motion. There is no clear rationale for the discrepancy in range of motion measurements. It should be noted that the records indicate that the patient has not been compliant with her medication regimen. The patient reportedly does not take her Ambien as prescribed secondary to internal conflict in the home, and the patient at one time borrowed a friend's morphine patch which made her pass out. The designated doctor in April recommended that the patient be referred to a shoulder specialist for a surgical evaluation. There is no indication that the patient is not a surgical candidate at this time, as required by current evidence based guidelines.

Given that the patient has failed to make significant progress in physical therapy and individual psychotherapy in the past, it is unlikely that the patient will receive any substantial benefit from a work hardening program at this time. Given the current clinical data, objective and subjective findings, 10 sessions of work hardening are not indicated as medically necessary.

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

Official Disability Guidelines, Work Loss Data Institute

1435179.1