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Notice of Independent Review Decision

Texas Department of Insurance
Health & Workers' Compensation Network Certification
and QA Division (HWCN) MC 103-5A
Sent via E-mail: IRODecisions@tdi.state.tx.us

Name:

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 03/04/2010

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening, additional 10 sessions (5 days/week x 2 weeks) right shoulder 97545

REVIEW OUTCOME

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

Overtuned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 11-11-08 MRI right shoulder read by Dr.
- o 11-11-08 MRI lumbar spine read by Dr.
- o 01-20-09 Behavioral Assessment of Pain, unsigned
- o 02-12-09 Electrodiagnostic report from Neurodiagnostic.
- o 03-12-09 Job Description provided by Dr.
- o 10-27-09 Progress report from Dr.
- o 12-01-09 Shoulder strength and range of motion studies/FCE, unsigned
- o 12-02-09 Evaluation Summary report from, DC
- o 12-29-09 Progress report from Dr.
- o 01-26-10 Work Hardening Progress Report/FCE from Dr.
- o 01-26-10 Progress report from Dr.
- o 01-26-10 TWCC form from Dr.
- o 01-26-10 Statement of Medical Necessity for Work Hardening from Dr.
- o 01-26-10 Request for additional work hardening, final 80 hours from Dr.
- o 01-26-10 Pre-Authorization request for additional Post-Surgical Work Hardening from D.C.
- o 02-01-10 Adverse Determination letter
- o 02-08-10 Fax appeal from Dr.

- o 02-08-10 IRO Position Statement from Dr.
- o 02-08-10 Asphalt Roller position sheet from Dr.
- o 02-15-10 Adverse Determination letter for reconsideration
- o 02-16-10 Letter notifying Adverse Determination for reconsideration
- o 02-17-10 request for IRO from the Claimant
- o 02-17-10 Confirmation of receipt of IRO from TDI
- o 02-18-10 Notification of Case Assignment of IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient is a who sustained an industrial injury to the head, neck, shoulders and back when he slipped after leaving the shower on xx/xx/xx.

Lumbar MRI performed November 11, 2008 revealed borderline central canal stenosis at L2-3 with crowding or mild impingement of the intrathecal nerve roots at that level secondary to spondylitic disc bulging and degenerative facet arthrosis. At L3-4 stenosis of the spinal canal, thecal sac and subarticular recesses secondary to spondylitic disc bulging and advanced degenerative facet disease. There is impingement of the thecal sac, intrathecal nerve roots and probable impingement of the proximal L4 nerve roots. Bilateral foraminal stenosis at L3-4 impinging exiting L3 nerve roots. Mild spondylitic disc disease at L4-5 without stenosis or neural impingement. A contiguous posterolateral bone fusion mass involves the facet joints of L4-5 and L5-S1 without complication. Bilateral subarticular recess stenosis at L5-S1 secondary to the spondylitic disc bulging and medial hypertrophy of the facet joints impinging proximal S1 nerve roots within subarticular recesses.

Right shoulder MRI was performed on xx/xx/xx and given impression: Mild type II acromion with positive lateral sloping and degenerative hypertrophy of the AC joint impinging the anterior myotendinous junction of the supraspinatus muscle and tendon. Supraspinatus tendinosis and partial thickness acromial surface tear of the supraspinatus tendon.

According to a Behavioral Assessment of Pain report dated xx/xx/xx the patient has four sites of pain. The patient liked his job. He demonstrates a fear of reinjury, a high expectation for cure and low acceptance of pain. He has been in pain for 12-18 months. He perceives a need for narcotic medication, additional treatment and additional diagnostics. He feels minimally improved (30%) since the injury. He shows a moderate level of depression and anxiety and sleep disturbance. His pain ranges from 4-5/10. He has minimal confidence is being able to return to work or begin vocational rehab (10%).

Electrodiagnostic studies performed on February 12, 2009 were interpreted to show a normal nerve conduction study and evidence with EMG of polyphasic muscle potentials in the right triceps and FDI with reduced recruitment. Conclusions state, chronic right C7 radiculopathic process in state of re-innervation.

The patient underwent an extensive right shoulder surgery on xx/xx/xx with repair of almost 2/3 of the circumference of the labrum and extensive rotator cuff repair.

The patient initiated physical therapy on September 21, 2009.

On October 27, 2009 the provider recommended additional physical therapy and home exercises. An extended recovery was anticipated.

A reassessment of isometric shoulder strength and range of motion was conducted on December 1, 2009 to graph improvements since the patient initiated PT on September 21, 2009 and since the prior assessment of October 27, 2009. Initial pectoralis major upper and lower strength for shoulder horizontal adduction was 3 pounds and was increased to 5 pounds on October 27, 2009 and to 14 pounds on December 1, 2009. Infraspinatus and teres minor strength was improved from 4 pounds to 7 pounds and then to 12 pounds. Subscapularis, pectoralis major and Latissimus dorsi strength for medial rotation was improved from 6 pounds to 10 pounds and then to 12 pounds. Grip strength on the right was improved from 9 pounds to 21 pounds and then to 24 pounds. Deltoid and anterior coracobrachialis strength for shoulder flexion was improved from 5 pounds to 14 pounds. Deltoid and middle supraspinatus strength for shoulder abduction was improved from 4 pounds to 8 pounds and then to 12 pounds. Shoulder rotation ROM was increased from 11 degrees to 39 degrees and has remain at a plateau. Shoulder flexion/extension ROM was improved from 25 and 9 degrees to 74 and 33 degrees and then to 113 and 41 degrees. Right shoulder adduction/abduction ROM history was improved from 18 and 16 degrees to 20 and 68 degrees and then to 23 and 107 degrees.

The patient underwent physical capacity assessment on December 2, 2009 and was determined to be functioning at a Light Physical Demand Level. His job reportedly requires a Very Heavy PDL. He was able to lift 15 pounds to shoulder height. He was able to carry 20 pounds. His job requires lifting and carrying of 110 pounds.

The patient was reassessed by the provider on December 29, 2009. He was improving with PT and home exercise. Due his extensive surgery he will likely need 6-12 months of post-op rehabilitation. According to the patient PT has finished and he is awaiting work hardening. The therapists need to be very careful with this patient due his extensive surgery.

At some point the patient initiated work hardening and attended 10 sessions. According to a pre-authorization request for ten additional sessions, he has been very compliant and has made excellent progress. He understand that the goal of a Very Heavy PDL may be too ambitious and that a goal of Heavy PDL is a much more realistic expectation. He further understands that at the completion of the program he will be returned to work at whichever capacity he achieves, even if it is not his pre-injury capacity (Very Heavy). The patient has a heavy/very heavy job demand and is currently unable to meet this job demand due his low back, right shoulder and cervical conditions as demonstrated the attached FCE. He has completed PT. Per his orthopedist, he is not a candidate for further PT and work hardening has been recommended. He is not a candidate for further surgery. The employer

has been contacted several times without response, so the patient has been working with a licensed clinical social worker that is working with prospective employers for a post rehabilitation job placement. A position has been found for which he is a candidate of he is able to meet his prior job demand.

According to a Work Hardening Progress report dated January 26, 2010 the patient initiated work hardening at 26.25% of his needed work capacity and currently is at 45%. 85% of his needed work capacity [an approximately 80% improvement.] The progress report documents various lifting, pushing and pulling capacities at initial assessment and per the current progress FCE. Improvements range from 33% to more than 100% (for carrying).

Request for additional work hardening, the final 80 hours, was considered in review on February 1, 2010 with recommendation for non-certification. The request is stated as 1x/week x 10 weeks (additional 10 sessions). The patient is status post 10 sessions of work hardening. He is reported to be compliant and making progress and at a Medium PDL. His job requires a very heavy PDL. His use of narcotics has decreased and his anxiety score has improved from 16 to 7. Request is for an additional 10 sessions. He is using hydrocodone 2 tablets daily and Lunesta every night. A peer discussion was attempted but apparently not realized. The request was denied with rationale that the patient has had less than 50 percent improvement from the initial 10 sessions in his physical demand level. The requested program "duration of 10 weeks" does not meet guideline duration and frequency recommendations of 20 visits over four weeks (160 hours). The program should entail continuous treatment of at least 3-5 days per week to fully progress. The provider did not state the specific work of the patient and his work activities to determine if the program was actually a simulation of his job specifications. Additionally a defined return to work plan agreed to by the employer and employee is a guideline requirement; a formal agreement was not presented for return to work.

Request for reconsideration, additional post surgical work hardening - final 80 hours/10 sessions was considered in review on February 15, 2010 with recommendation for non-certification. The requested appeal was stated as work hardening 5x/week for two weeks. A peer discussion was attempted but not realized. Per the reviewer, despite the clarification of the patient's work demands and activities of the job, as well as the duration and frequency of the requested program (2/15/10 - 2/26/10), the clinical information submitted for review fails to fully establish the medical necessity of the request. The efforts to contact the employer and obtain a formal return to work plan are appreciated, but the referenced guidelines are maintained to this point with regards to a formal documentation of such an agreement. It is noted that a licensed social worker is working with prospective employer for a post rehabilitation job placement. Hence, there is a need for clarification with regard to the present employment of the patient. If he has already changed employment there would also be different work demands. It is noted that the FCE results show good improvement with further gains expected to realize a viable return to work. Per guidelines, outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. However, such initial goals were not presented for review.

Request was made for an IRO. An IRO position statement was submitted: The initial denial was based on a misinterpretation of the duration and frequency desired for additional work hardening. The initial reviewer requested a job description and a defined return-to-work goal for the patient. The employer has not responded to repeated contacts, so a licensed clinical social worker is working with prospective employers for a post rehabilitation job placement in a job with the same physical demand level. A position has been found for which he is a candidate if he is able to meet his prior job demand. An position notice is attached. The patient has signed the defined return-to-work goal to reach the heavy job demand so that he can return to work without restrictions (attached). In regard to the goals presented upon entry as identified in the screening process, please see the patient's starting ability as noted in the Work Hardening Progress Report. To this point, the patient has been compliant and completed the initial course of work hardening with excellent response, and further gains are expected toward meeting program goals.

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

The first line reviewer recommended non-certification based on rationale that the patient "has had less than 50 percent improvement from the initial 10 sessions in his physical demand level." There was a misunderstanding regarding the duration and frequency of the desired additional 10 sessions. It was noted that the provider did not state the specific work of the patient and his work activities to determine if the program was actually a simulation of his job specifications. Additionally a defined return to work plan agreed to by the employer and employee is a guideline requirement; a formal agreement was not presented for return to work.

The second-line reviewer recommended non-certification despite clarification of the duration and frequency of the requested sessions as well as clarification of the difficulties with the employer in regard to a return to work plan. As noted in the initial review, the patient's use of narcotics has decreased and his anxiety score has improved from 16 to 7. A work hardening progress report was submitted which indicates the patient initiated work hardening at 26.25% of his needed work capacity and currently is at 45.85% of his needed work capacity. The progress report also documents various lifting, pushing and pulling capacities at initial assessment and at reassessment FCE which indicate improvements ranging from 33% to more than 100% (for carrying).

Per ODG, (9) the ideal situation is that there is a plan agreed to by the employer and employee. The ideal cannot be realized in this situation as the employer is not responding to the patient. Per ODG (17), Voc rehab: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to. This indicates that work hardening is not entirely dependent on having a job. In this case the patient is attempting to regain a heavy/very heavy work

demand and has completed an initial 10 sessions of work hardening with marked improvements. It is also noted above, during approximately nine weeks of pre-work hardening PT the patient was able to increase his shoulder horizontal adduction strength over 300%, medial rotation strength 100%, grip strength almost 300%, shoulder rotation ROM 350%, shoulder flexion/extension ROM 450% and 82%, and shoulder adduction/abduction ROM 26% and over 600%. This patient demonstrates strong gains with treatment. ODG allows for up to 20 full-day visits over 4 weeks. The patient has completed 10 sessions over two weeks and is seeking an additional 10 sessions over two weeks which appears to be medically appropriate.

Therefore, recommendation is to disagree with the previous non-certification for an additional 10 sessions of work hardening for the right shoulder.

The IRO's decision is consistent with the following 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

The Official Disability Guidelines (02-12-2010) Shoulder - Work Conditioning/Work Hardening:

Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip, knee, shoulder and forearm. 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.

Criteria for admission to a Work Hardening (WH) Program:(1) Prescription: The program has been recommended by a physician or nurse case manager, and a prescription has been provided. (2) Screening Documentation: Approval of the program should

include evidence of a screening evaluation. (3) Job demands: A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).(4) Functional capacity evaluations (FCEs): A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.(5) Previous PT: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.(6) Rule out surgery: The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).(7) Healing: 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.(8) Other contraindications: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.(9) RTW plan: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities. (10) Drug problems: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification. (11) Program documentation: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.(12) Further mental health evaluation: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning. (13) Supervision: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff. (14) Trial: 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 improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.(16) Conferences: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented. (17) Voc rehab: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.(19) Program timelines: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.ODG Work Conditioning (WC) Physical Therapy GuidelinesWC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.