



# IMED, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 06/21/11

**IRO CASE NO.:**

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

Item in dispute: Appeal Addtl Work Conditioning 5 x wk x 2 weeks 6 hrs/day Multiple Sites 97545 97546

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

Texas Board Certified Physical Medicine & Rehabilitation  
Texas Board Certified Pain Management

**REVIEW OUTCOME**

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

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. 10/04/10 – Clinical Note –M.D.
2. 10/12/10 – Clinical Note –M.D.
3. 10/19/10 – Clinical Note –M.D.
4. 10/26/10 – Clinical Note –M.D.
5. 11/02/10 – Clinical Note –M.D.
6. 11/08/10 – MRI Right Shoulder
7. 11/08/10 – MRI Cervical Spine
8. 11/08/10 – MRI Thoracic Spine
9. 11/08/10 – MRI Lumbar Spine
10. 11/10/10 – MRI Right Knee
11. 11/16/10 – Clinical Note –M.D.
12. 11/18/10 – MRI Right Ankle
13. 11/20/10 – Clinical Note –M.D.
14. 12/09/10 – Clinical Note –M.D.
15. 12/22/10 – CT Abdomen/Pelvis
16. 12/27/10 – Clinical Note –M.D.
17. 01/14/11 – Clinical Note –M.D.

- 18.01/21/11 – Clinical Note –M.D.
- 19.02/14/11 – Clinical Note –M.D.
- 20.02/15/11 – Functional Capacity Evaluation
- 21.03/11/11 – Clinical Note –M.D.
- 22.04/13/11 – Functional Capacity Evaluation
- 23.04/18/11 – Work Conditioning Weekly Progress Note
- 24.04/19/11 – Pre-Certification Request
- 25.04/27/11 – Notification of Adverse Determination
- 26.05/03/11 – Appeal Letter –DC
- 27.05/18/11 – Notification of Reconsideration Determination
- 28.06/09/11 – Notice to Utilization Review Agent of Assignment
- 29. ***Official Disability Guidelines***

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a female who sustained an injury on xx/xx/xx when she slipped and fell on a wet floor, hurting her back, neck, right shoulder, elbow, hand, and bilateral knees.

The employee saw Dr. on 10/04/10 with complaints of pain to the neck, right shoulder, elbow, thoracic spine, lumbar spine, and knee rating 9 out of 10. Physical examination reveals decreased range of motion of the cervical spine. There was muscle spasm of the cervical spine. There was tenderness to palpation of the bilateral trapezius muscles. There was decreased muscle strength of the right arm. There was tenderness to palpation of the anterior right shoulder and bicipital groove. There was decreased range of motion of the thoracic spine. There was tenderness to palpation. There was decreased range of motion of the lumbar spine. Sitting straight leg raise was noted to be positive bilaterally. Range of motion of the knee reveals flexion to 95 degrees. There was diffuse tenderness to palpation of the knee. McMurray's was negative. The employee was assessed with bilateral lumbar sprain, bilateral knee and leg sprain, thoracic sprain/strain, elbow/forearm sprain/strain, hand sprain, neck sprain, and knee contusion. The employee was recommended for physical therapy. The employee was prescribed Naprosyn, Flexeril, and Ultracet.

MRI of the right shoulder performed 11/08/10 demonstrated Grade I strain involving the distal supraspinatus tendon versus mild tendinosis. There was no evidence of full thickness rotator cuff tears. There was small glenohumeral joint effusion and a small subacromial/subdeltoid bursitis. A potential source for rotator cuff impingement was acromioclavicular joint arthrosis.

MRI of the cervical spine performed 11/08/10 demonstrated a broad 1 mm disc protrusion at C4-C5 with a 2mm right paracentral component. There was no canal stenosis or neural foraminal encroachment. At C5-C6, there was a broad 1 mm disc protrusion with a 2 mm right paracentral component and mild central canal stenosis.

The neural foramina are patent. At C6-C7, there was a broad 1 mm disc protrusion with no canal stenosis or neural foraminal encroachment.

MRI of the thoracic spine performed 11/08/10 was unremarkable. The heights of the thoracic vertebral bodies are preserved with no compression fracture or listhesis. There

was no disc herniation, canal stenosis, or neural foraminal encroachment at any thoracic level.

MRI of the lumbar spine performed 11/08/10 demonstrated preserved heights of the lumbar vertebral bodies with no compression fracture or listhesis. At L2-L3, there was a 2 mm right paracentral protrusion with very mild central canal stenosis. The neural foramina are patent. At L4-L5, there was a broad 1 mm disc protrusion with a 2mm central component and a zone of hyperintensity on T2. There was no canal stenosis or neural foraminal encroachment. There was no facet hypertrophy or ligamentum flavum thickening. At L5-S1, there was a broad 1-2 mm disc protrusion with a central zone of hyperintensity on T2. There was no canal stenosis or neural foraminal encroachment identified. There was no facet hypertrophy or ligamentum flavum thickening.

MRI of the right knee performed 11/10/10 demonstrated intact anterior and posterior cruciate ligaments. There was a small amount of subcutaneous edema within the prepatellar area. No prepatellar bursitis was present. There are no meniscal tears. There are no medial or lateral compartment articular cartilage defects seen. Patellofemoral alignment was maintained. The patellar articular cartilage was edematous with very mild fissuring. There are no destructive bone lesions seen.

MRI of the right ankle performed 11/18/10 demonstrated mild tibialis posterior tenosynovitis within the medial ankle. The adjacent medial deltoid ligament complex was normal in appearance. There was mild lateral subcutaneous edema with intact underlying peroneal tendons and lateral ligament complex. There are small ankle effusions noted.

CT of the abdomen and pelvis performed 12/22/10 demonstrated moderate generalized colonic fecal stasis. There was no evidence of acute intra-abdominal or pelvic neoplastic or inflammatory process. There was a 2 mm right ovarian cyst. There was left basilar atelectasis.

The employee saw Dr. on 12/27/10 with continued pain complaints. Physical examination reveals full range of motion of the cervical spine. There was tenderness to palpation of the anterior right shoulder with full range of motion. There was tenderness and muscle spasm to palpation of the thoracic and lumbar spine. Sitting straight leg raise was reported to be positive. The employee was assessed with bilateral lumbar sprain, bilateral knee sprain, thoracic sprain/strain, elbow/forearm sprain/strain, hand sprain, and neck sprain. The employee was recommended for continued physical therapy.

The employee saw Dr. on 01/14/11 with complaints of pain in the right shoulder, low back, and right ankle rating 4 to 8 out of 10. Physical examination reveals full range of motion of the cervical spine. Bilateral trapezius muscle spasm was noted. There was tenderness to palpation. There was tenderness and muscle spasm to palpation of the thoracic spine. There was tenderness and muscle spasm to palpation of the lumbar paraspinal muscles. Sitting straight leg raise was reported to be positive on the right. There was tenderness to palpation of the right medial malleolus. The employee was assessed with bilateral lumbar sprain, bilateral knee sprain, thoracic sprain/strain,

elbow/forearm sprain/strain, neck sprain, and knee contusion. The employee was prescribed Naprosyn, Flexeril, and Ultracet.

The employee saw Dr. on 02/14/11 with continued pain complaints. Physical examination reveals full range of motion of the cervical spine. There was bilateral trapezius muscle spasm noted. Tenderness to palpation was noted to be decreased. Muscle spasm and tenderness of the thoracic spine are noted to be decreased. There was full range of motion of the lower extremities. The employee was recommended for Functional Capacity Evaluation and possible work conditioning.

An FCE was performed on 02/15/11. The employee's occupation requires a medium physical demand level. The employee was capable of performing at a light physical demand level.

The employee saw Dr. on 03/11/11 with complaints of pain in the right knee, right shoulder, and low back rating 4 out of 10. Physical examination reveals full range of motion of the cervical spine. Bilateral trapezius muscle spasm was noted. There was full range of motion of the thoracic spine. Muscle spasm and tenderness to palpation was noted to be decreased. There was full range of motion of the bilateral knees. The employee was assessed with bilateral lumbar sprain, bilateral knee sprain, thoracic sprain/strain, elbow/forearm sprain/strain, hand sprain, neck sprain, and knee contusion. The employee was prescribed Naprosyn and Flexeril. The employee was recommended for work conditioning.

An FCE was performed on 04/13/11. The employee's occupation requires a medium physical demand level. The employee was capable of performing at a medium physical demand level. The employee was recommended for 10 days of a work-conditioning program.

A work conditioning weekly progress note dated 04/18/11 indicated the employee shows good motivation and effort. The employee was currently functioning in the medium work level. The employee has attended 80% of the program. The note states the employee continues to have limitations with lifting instability, prolonged walking, kneeling, crawling, squatting, and over-reliance with pain medication. The employee also reports pain with range of motion. The employee was recommended for additional work conditioning.

The request for additional work conditioning was denied by utilization review on 04/27/11 due to no serial physical therapy progress notes that validate the dates, number of visits, and functional response from the previously rendered physical therapy. The most recent FCE dated 04/13/11 noted that the employee has not reached a functional level that would allow her to return to work safely. However, as per FCE dated 02/15/11, the required PDL was noted to be Medium PDL, which the employee has now achieved. With the gains made, there was currently no indication that a less intensive rehabilitation program cannot address the remaining deficits. There are no extenuating circumstances to support additional work conditioning since the employee has already met medium PDL goals and has had twice the recommended hours for work conditioning.

The request for additional work conditioning was denied by utilization review on 05/18/11 as the FCE dated 04/13/11 revealed the employee's current PDL rated as medium for an occupation requiring a medium PDL. Additionally, the number of requested hours exceeds guidelines recommendations. Given the employee previously completing a work conditioning program as well as meeting the requirements of the current occupation, and the excessive nature, this request did not meet guideline recommendations.

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

The requested additional work conditioning is not recommended as medically necessary. The employee has completed a work-conditioning program and the FCE provided demonstrates that the employee is able to meet the required physical demand level. There is no rationale provided on the continuing need for a work-conditioning program. There are no updated treatment plans or therapy goals. There are also no objective findings of significant functional limitations that would reasonably require the amount of work conditioning requested over the recommended 30 hours. As such, medically necessity is not supported.

### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

*Official Disability Guidelines*, Low Back Chapter

#### **ODG Work Conditioning (WC) Physical Therapy Guidelines**

WC 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.