



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

April 12, 2012

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**DATE OF REVIEW: 4/9/2012**

**IRO CASE #:**

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

Work hardening program x10 sessions, 8 hours a day.

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

Texas State Licensed Doctor of Chiropractic

**REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]**

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)

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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Assignment to 3/23/2012,
2. Notice of assignment to URA 3/22/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 3/23/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 3/23/2012
6. Adverse determination letter 3/15/2012, medical documents 3/8/2012, preauthorization request 3/8/2012, adverse determination letter 2/29/2012, initial interview 2/20/2012, medical information 2/20/2012, 2/10/2012, 11/28/2011, work status report 5/2/2011, strength report, functional capacity evaluation 4/29/2011, report of medical evaluation 4/26/2011, patient's job specifications.

**PATIENT CLINICAL HISTORY:**

The patient was a right-handed adult male. His date of injury is listed as xx/xx/xx.  
The former group identified his job title as while the latter group tended to identify his job as. Although both jobs share some job duties, they are not identical.



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After examining the records, it appears that since he was at a “Sedentary” level on the Physical Demand Level (PDL) assessment that he was unable to return to the. His designated physician states in his report that the patient was terminated from his job. It was reported that a Senior Human Resources Generalist for the advised the patient was given a “medical separation” as of 09/12/2011.

There seems to be confusion in regards to the nature of the injury. The question is whether this was a one-time injury, discrete event, or a culmination of repetitive injuries and stresses over time. The documentation of the treating doctors and report from the patient himself, that the on the job injuries became acute and could no longer be tolerated on the date given, however, it also appears that the malfunctioning of devices which he had to manipulate to do his job, caused an ongoing trauma over the five to six months he was working in his position, and that these repetitive injuries set the stage for the traumatic deterministic event of January 20, 2011.

The history is that he reported his injury to his supervisor on xx/xx/xx, and was sent to. The patient was examined by the attending physician and diagnosed with a shoulder sprain/strain, and was returned to work on a modified duty status. He quickly discovered he could not perform even the modified duties due to pain, and found his own treating physician. After the physician examined the patient, he was referred to physical therapy for the neck and right shoulder, and was prescribed medications for the pain (including Hydrocodone, Celebrex, and Methocarbamol). The patient reported an increase in pain secondary to physical therapy and was referred to have an MRI of the c-spine and rotator cuff on April 13, 2011. The MRI demonstrated a disc herniation at the C4-5 level (with an element of central stenosis, perhaps congenital), approximately 3 mm in magnitude, which was flattening the thecal sac. The MRI of the right shoulder disclosed a partial thickness tear at the insertion point of the supraspinatus tendon with an intact labrum. He was subsequently referred to an orthopedic surgeon. The physician reportedly felt that surgery was not indicated at that time, and that possibly in a six month time frame, the tear may heal, and if it did not, then surgery may be needed. The patient was also referred to a neurologist for evaluation of the cervical spine. After this, the patient was referred for a CT myelogram of the c-spine. The treating physician prescribed 4 sessions of active care centered on the right shoulder and c-spine.

The physician noted the patient continued to exhibit guarding and fear of re-aggravating his neck and right shoulder and decided he had reached a plateau from this protocol. He was referred to an orthopedic surgeon who advised continuing with a conservative regimen, as the patient stated he did not want any injections or surgical intervention.

The patient was given a Functional Capacity Evaluation (FCE) on or about 02/20/2012 which documented he was only functioning at a “SEDENTARY” physical demand level. The physician examined the patient on 04/26/2011 and determined him to be at Maximum Medical Improvement (MMI) with a zero (0) percent whole body impairment, zero shoulder / arm



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impairment and placed his date of Maximum Medical Improvement (MMI) to be March 11, 2011.

The patient was seen on 11/17/2011, ostensibly to determine extent of injury issues. The physician determined that the patient's past history was non-contributory to his presenting problems. In his report, he also notes the treating doctor had projected a Maximum Medical Improvement (MMI) date for the patient of 11/30/2011. The physician found that the cervical spine and right shoulder were compensable areas of injury on this patient.

The physician referred the patient back to the treating doctor to schedule a consultation with an orthopedic surgeon for a shoulder evaluation, a neurosurgeon (for the cervical spine), and a pain management specialist (for the cervical spine).

The treating doctor referred the patient to an orthopedic surgeon for the shoulder evaluation, but no note was provided from a neurosurgeon, only a note about a neurologist, seeing the patient. The note about the neurologist said a CT myelogram was ordered, however none were included in the reports.

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

From the documents provided, it appears that the patient is reporting very high levels of pain, from an "8" to a "10" on a 0-10 relative pain scale. It also appears that pain tends to be a limiting factor in interfering with the activities of daily living and keeping him from functioning at a Higher Physical Demand level (PDL) level. The most recent evaluations of the patient fail to document any significant improvement in his pain levels and in general, demonstrate a general failure of improvement in this patient's condition. It is very possible that the herniated cervical disc and partial tear of the supraspinatus component of the rotator cuff of the right shoulder are major contributors to his pain levels, but the patient is not willing to have any surgical intervention or injections to the injured areas, so they will most likely continue to be pain generators regardless of any participation in a work hardening program.

The requesting doctor has requested "*10 sessions of highly structured work hardening program*". The designated doctor was asked to determine whether the patient has reached Maximum Medical Improvement (MMI), and if so, what percentage of impairment is appropriate. The physician has already found the patient at Maximum Medical Improvement (MMI) on 03/11/2011.

Maximum Medical Improvement (MMI) in Texas is defined in Sec. 401.011 of Title 5 of the Labor Code as:

(30) "Maximum medical improvement" means the earlier of:

(A) the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated;



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(B) the expiration of 104 weeks from the date on which income benefits begin to accrue; or (C) the date determined as provided by Section 408.104. The patient was not 104 weeks after his accident, and thus, this Maximum Medical Improvement (MMI) must be a clinical Maximum Medical Improvement (MMI) determination, which means that further material recovery from, or lasting improvement to an injury, can no longer be reasonably anticipated. This would indicate that the work hardening program cannot be reasonably expected to improve his status at this point. This is supported by the fact that the objective testing continues to find him at a sedentary level, and apparently this has not changed since his initial testing. The two main diagnoses include a cervical disc herniation and a partial thickness tear of the supraspinatus tendon.

Referring to the ODG guidelines on the appropriate use of work hardening programs, under “Criteria for admission to a Work Hardening (WH) Program” 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.” It can be argued that the existence of a herniated disc in the c-spine, with some degree of central stenosis, which has not been evaluated by a neurosurgeon, despite the order of the second designated doctor, may represent such a co-morbid condition which may serve as a contraindication, depending on the severity of this cervical lesion.

The initial examination of 02/20/2012 performed and was concluded that the patient has a pain disorder with both psychological factors and a general medical condition with pain, job concerns, financial struggles, multiple social losses and problems with family as well as severe depression and anxiety based on self-reporting and self assessment questionnaires.

In the ODG criteria for admittance into a work hardening program, it states:

“The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient’s program should reflect this assessment.”

Given that the patient has issues with limiting his exertion due to pain perhaps arising from both a herniated disc in the cervical spine and the partial thickness tear of the supraspinatus tendon, he seems to have made essentially no progress with a home exercise program nor from the physical therapy treatment already received, and that his pain levels continue at very high levels despite the medical management with multiple medications. There is no evidence that this patient would be a good candidate for a work hardening program. There is little evidence that would support any optimism that a work hardening program would be able to decrease his pain levels nor increase his functional status enough such that he would be able to go from a sedentary Physical Demand Level (PDL) to a Medium or even Heavy Physical Demand Level (PDL). Furthermore, there was a notation of the indication of a “submaximal effort” during the Functional Capacity Evaluation (FCE) performed on or about 02/20/2012 in which the patient was reportedly capable of occasional dynamic lifts up to 10 pounds on all lifts tested. NIOSH lifts were performed up to



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6-7 pounds, and as noted, these lifts are static and should be at least double the dynamic lifts, which means the patient should have accomplished around a 20 pound static lift, and this would indicate a submaximal effort and thus, this could invalidate the Functional Capacity Evaluations (FCE's) conclusions if the patient was not giving a good faith maximal effort. Without a valid Functional Capacity Evaluation (FCE), one of the essential requirements of the entry into a work hardening program would not be met. From the current ODG guidelines:

“(4) Functional Capacity Evaluations (FCEs): A valid functional capacity evaluations 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.”

### **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)