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Notice of Independent Review Decision

IRO REVIEWER REPORT TEMPLATE – WC

March 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening program x 80 hours/units

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

Board Certified Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Office visits (03/03/11 – 10/11/12)
- PT daily notes (03/04/11 – 03/14/11)
- Surgery (10/02/12)

- Office visits (03/20/12 – 01/16/13)
- FCE (12/18/12)
- Utilization reviews (01/18/13)

- FCE (12/18/12)
- Office visits (12/20/12 – 01/03/13)
- Utilization reviews (01/18/13, 02/04/13)

TDI

- Utilization reviews (01/18/13, 02/04/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was standing on a three-step ladder on xxxxxxx. Upon pulling and pushing the ladder slid on the sand causing him to fall. As he fell, he used his left hand to break his fall.

2011: On xxxxxx evaluated the patient for left wrist pain that was shooting and burning, decreased range of motion (ROM) on wrist flexion, extension, ulnar deviation, radial deviation, supination and pronation. There was decreased strength and swelling. Examination of the left hand/wrist revealed edema on the dorsum of the hand and extensor surface of the wrist, decreased ROM, tenderness on the extensor tendons, flexor tendons and extensor pollicis longus and brevis, decreased grip strength and decreased extension. Finkelstein's test was positive. X-rays were negative for fracture or dislocation. diagnosed tenosynovitis of the left wrist/hand, prescribed Lodine, Flexeril and Ultracet; provided a left wrist brace with thumb spica and recommended physical therapy (PT).

From xxxxx, through xxxxx, the patient attended four sessions of PT consisting of neuromuscular re-education, therapeutic activities and therapeutic exercises and training in activities of daily living (ADL)/self care/home exercise program (HEP).

On xxxxx, noted that overall the symptoms remained the same. He recommended further rehab because of persistent pain.

On xxxx evaluated the patient for left wrist pain. The patient had been evaluated. A physical performance evaluation (PPE) dated xxxxx, had revealed decreased motion, decreased function and decreased strength. had recommended continuing splinting. diagnosed left wrist sprain/strain and internal derangement. He recommended follow-up and requested for records/magnetic resonance imaging (MRI).

On xxxxx noted that the patient was utilizing cyclobenzaprine, acetaminophen and etodolac. requested for records. He noted that the patient was scheduled for a designated doctor evaluation (DDE).

On xxxxx noted ongoing left wrist pain. The patient was status post surgery with on xxxxx. had recommended beginning rehab. recommended continuing medications.

2012: On xxxxx noted that the patient had attended five sessions of rehab to his left hand. Examination revealed decreased ROM, decreased strength and decreased sensory. prescribed ibuprofen, Flexeril, Ultracet and recommended continuing therapy. He recommended a functional capacity evaluation (FCE) post rehab. Hydrocodone was discontinued.

On xxxxx, the patient underwent work hardening program (WHP) evaluation. The evaluators felt that the patient had a realistic opportunity to benefit from this program.

On xxxxx noted that the patient had undergone FCE that showed decreased motion, strength, function and evidence of anxiety and depression. stated there was a need for increased ROM and strength which could not be accomplished with HEP. The surgeon had recommended additional therapy.

On xxxxx, the patient underwent behavioral medicine consultation. The evaluator noted the following treatment history: *The patient reported that he threw his ladder off balance and caused him to fall to the floor injuring his left wrist/hand. The patient sought treatment with the company doctor where he was put on light duty and attended 12 sessions of PT. He also had injection to his wrist. He underwent surgical repair to his wrist on xxxxx, and had 16 sessions of postop PT.* The patient scored 25 on Beck Depression Inventory (BDI) indicating moderate depression and 24 on Beck Anxiety Inventory (BAI) consistent with moderate anxiety. The evaluator diagnosed pain disorder associated with psychological factors and a general medical condition, chronic and major depressive disorder, single episode, moderate. The patient was felt to be an excellent candidate for WHP.

On xxxxx evaluated the patient for pain to the left thumb and a trigger of the left thumb. Examination revealed point tenderness to the triangular fibrocartilage area. The ROM was much improved. There was a definite trigger to the left thumb. injected the A1 pulley with 5 mg of Kenalog and recommended follow-up in two weeks.

On xxxxx noted that the patient was unable to return to full duty. The request and appeal for the return to work program had been denied. recommended follow-up.

On xxxxxx noted that the patient had failed to respond to multiple Kenalog injections. He had splinting and therapy with no improvement of his trigger condition. Examination revealed marked tenderness along the flexor pollicis longus with a clear enlargement of the A1 pulley and a very painful A1 pulley on superficial and deep palpation. He recommended A1 pulley release and synovectomy of the flexor pollicis longus of the left thumb.

On xxxxx performed release of A1 pulley of left thumb and synovectomy of flexor pollicis longus. Postoperatively applied ortho-glass splint and recommended therapy.

Per an FCE dated xxxxx, the evaluator felt that any referrals the treating doctor would feel necessary will help the patient's condition and recommended WHP.

On xxxxx noted that the patient had completed nine sessions of postop rehab. He recommended WHP.

2013: On xxxxxx noted the following treatment history: *Following the injury, the patient sought medical attention at Nova. He had no x-rays but was released to return to work the next day. He was also provided with PT while he continued to work. PT made his injury worse as his left hand swelled up. In May 2011, he saw who placed a removable cast on his left hand and advised against surgery. He underwent surgery x2 and had postsurgical PT. He did not make sufficient recovery to meet his job PDL.* The patient scored 18 on BAI reflecting moderate anxiety and 10 on BDI indicating minimal depression. Ms. diagnosed pain disorder associated with both psychological factors and a general medical condition, chronic and panic disorders without agoraphobia. She recommended WHP.

Per pre-auth request for WHP the patient had modest improvement with outpatient PT. The FCE dated xxxxxx, had revealed that the patient was functioning at sedentary-light PDL versus heavy PDL required by his job.

Per utilization review dated xxxxxx, the request for WHP for the left wrist – 80 hours (10 sessions) was denied with the following rationale: *"The clinical indication and necessity of this procedure could not be established. The below FCE manifested performance at a Sedentary-Light PDL versus the Heavy PDL apparently required for his job. However, it should be noted that where significant pain behavior is noted, an FCE is not necessarily reliable and valid in a patient with a chronic benign pain presentation. This is not addressed in the below mental health evaluation. In addition, the utilized psychometric instruments are inadequate/inappropriate to elucidate the pain problem, explicate psychological dysfunction, or inform differential diagnosis in this case; and there is no substantive behavior analysis to provide relevant clinical/diagnostic information. There is no indication/documentation from the treating physician affirm that all other appropriate care for this problem has now been exhausted. His exam of xxxxxxx also shows no awareness of the second surgery, and there is no Review of Systems. He records the patient is using only Advil. The below FCE reports tramadol and cyclobenzaprine; and the mental health evaluation reports the patient denying using medication. This is confusing. I am not able to establish a basis that this treatment is both reasonable and necessary at this time."*

On xxxxxxx appealed for WHP. She reported that the patient still had his job to return to as a machine operator for . The last day he worked was on xxxxxx. He had plans to return to the same position and the same employer. Given that he was not close to his PDL he was encouraged to consider an alternative vocational plan (ex: possibly get him to contact employer to see if he can move to another department or job title with a lower PDL (medium) or another type of job with a

different employer that has a medium PDL job). He would benefit from vocational counseling offered in the program.

Per reconsideration review dated xxxxxx, the appeal for work hardening for the left wrist – 80 hours (10 sessions) was denied with the following rationale: *"Clinical data submitted indicates the worker sustained a wrist injury almost two year ago and has undergone arthroscopy for TFCC tear and debridement and repair of scapholunate ligament (either September 27, 2011 or September 29, 2011) with 15 postoperative hand therapy sessions that were later followed by a second procedure, radial flexor tendon sheath incision and synovectomy (October 2, 2012) with 9 postoperative physical therapy sessions. The recommendation for work hardening was initiated December 20, 2012. The worker participated in a mental health evaluation and a functional capacity evaluation, the latter indicating a sedentary to light physical capacity versus a heavy category job description due to task that may require handling buckets of sand weighing up to sixty pounds and other unnamed tasks requiring material-handling ability to 100 pounds. The extent to which transitional work duty or accommodations might be available is not clear at this time; however, it is noted the worker no longer retains (or apparently has access to) his former position as machine operator/production worker. The worker has not been employed since the date of injury, which is more likely than not one of the major contributors to his current psychosocial factors identified in the clinical interview. The records also indicate the worker was initially recommended non-surgical treatment but ultimately was determined to require surgical intervention for the ligamentous injuries as natural restorative healing did not occur. The worker reported the persistence of sharp and aching pain in the left wrist and decreased grip and pinch strength as the left thumb and wrist. There is no indication whether the worker has trialed a standard or thumb spica support of splint. Based on the mental health evaluation, there are likely to be clinically significant non-occupational psychosocial barriers to recovery that are not likely to be favorably impacted by a return to work program. The only medications cited are cyclobenzaprine, which is a tri-cyclic muscle relaxant, which is not likely to be favorably contributing to pain control of a wrist and thumb injury for which surgery has been performed. The medical necessity for the tramadol and acetaminophen combination is not clear in the absence of a non-steroidal anti-inflammatory drug for articular and associated soft tissue complaints. The worker has successfully recovered from prior orthopedic surgical procedures of the knee (1992) and right shoulder (2005 and 2006). It is unclear how the wrist injury evolved into a protracted course of disability and a functional-limiting chronic pain syndrome in the absence of complications. The various handgrip strength maneuvers do no correlate well with the sedentary to light physical demand level category selected. The various NIOSH lifts similarly do not correlate well with the physical impairment and/or the declaration of low level physical capacity. Pinch performances are similarly inconsistent with the identify level of ability. The evaluator's comment that aerobic evaluation could not be completed due to the level of pain associated with the thumb and wrist condition is curious as this assessment does not require use of the hand. The primary functions not performed or completed and for which perceived pain levels were elevated included reaching above the shoulder level, stooping, squatting, lifting,*

twisting, and walking (perceived pain level of 7/10). The physical therapist performing the functional capacity evaluation has recommended four to six weeks of participation in the work hardening program on the basis of the assessment, citing depression and lack of self-worth as primary psychosocial factors.

The Letter of Appeal addressed the concerns raised by the initial psychologist review, which did note the completion of a peer-to-peer discussion that apparently did not resolve the objections raised. First, the review indicates the worker's position maybe available; however, this was not the interpretation of the records presented. Minimal clinical data was apparently exchanged based on the documentation of the peer-to-peer discussion. The FCE was questioned as to relevance in the face of significant pain behavior which was then cited as a negative predictor of outcome for the work hardening program. The reviewer then opined the psychological tools used for the assessment were not acceptable (inadequate and inappropriate); however, clinical guidelines relating to work hardening program requires only a diagnostic interview in order to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. 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. The reviewer has also queried the reason the treating physician does not refer to a second surgical procedure and questions whether the physician can, therefore, be certain that no other options may be more appropriate.

At present, the issue most limiting favorable consideration of the work hardening program or any other multidisciplinary program is the seemingly great variance between the documented objective physical impairment and the functional limitations cited in the brief functional capacity evaluation. The worker's performance appears to contain subtle but clinically significant discrepancies not detected by the coefficients of variance incorporated into the computer-aided assessment. The worker's recovery has extended beyond the usual and customary timeframe following the second surgical procedure, which may reset the time table for functional recovery, but the underlying causes are not clearly identified and therefore are not amenable to such a program at this time.

Following the review of records, peer-to-peer discussion occurred allowing for more detailed assessment of the clinical disorder and the worker's presentation, performance and potential. The program's psychologist confirmed the worker is right hand dominant and the employer has indicated that (although) the worker does not have a position currently, he is eligible for rehire with a full duty release. It remains unclear whether the worker would be able to work with a thumb spica splint and pad. The worker is reported to score below the BDI cut-off for depression although anxiety level and fear-avoidance appear to be elevated. There are no clinically significant psychosocial issues or barriers identified other than the fact the worker has not been employed for the past year and one-half

and has expressed concern about his vocational future and his concern about his hand/wrist. The peer-to-peer discussion allowed for the review at some length of the disparity between the worker's age, the limited scope of the physical impairment (non-dominant thumb, hand and wrist only) and the poor performance on the functional capacity evaluation given his youth and the lack of physical impairment above the mid-forearm and for the right upper extremity, trunk and legs. It is also unclear if the use of a protective orthotic device might significantly improve the functional output of the assessment and expedite return to work more quickly than participation in a Functional Restoration Program (work hardening program). Based on the clinical data presented, review of the prior pre-certification data and the pee-to-peer discussion, there remain questions as to the medical necessity and appropriateness of this worker for enrollment in a full-day multi-week multidisciplinary rehabilitation program. There are inconsistencies and treatment options (splinting) that need further assessment at this time."

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

There are multiple reasons why this request does not meet ODG criteria and in addition a wrist/thumb or hand injury should not result in significant overall deconditioning requiring a work hardening program. In addition, it is two years post injury and records indicate he does have a position to return to and therefore is not recommended by ODG.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES