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Notice of Independent Review Decision

**Date: January 21, 2013**

**IRO CASE #:**

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

10 sessions of work hardening program

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

Fellow American Academy of Physical Medicine and Rehabilitation

**REVIEW OUTCOME:**

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

Upheld (Agree)

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient who on xx/xx/xx, was assigned to work. She worked a twelve-hour work shift performing the same type of work. She was only offered latex gloves instead of proper gloves, which did not protect her from the cold temperature. Halfway into her work shift, she requested that she be assigned to another job as she was having difficulty moving her hands. She was not transferred to a different job; she completed her work shift performing the same task. By the end of her work shift, she felt severe pain in her right hand, wrist and forearm.

Per work status information report dated January 17, 2012, evaluated the patient and recommended medications, restricted duty, referral to physical therapy (PT) and activity as tolerated for both hands.

On January 25, 2012, the patient underwent occupational therapy (OT) evaluation. Treatment plan was twelve sessions of OT consisting of therapeutic

exercises, manual therapy, electrical stimulation, hot/cold packs and home exercise program (HEP).

Per record dated January 26, 2012, recommended PT, medications and restricted duty.

On February 2, 2012, evaluated the patient for complaints in the bilateral hands/wrists. It was noted that the patient was initially seen by her primary care physician (PCP). Diagnosis was tenosynovitis. The patient had bilateral upper extremity pain that increased with use. Examination showed positive Finkelstein's test bilaterally, left greater than right. Diagnosis was tenosynovitis of the hand and wrist. recommended PT, limited use of the bilateral upper extremity, non-steroidal anti-inflammatory drugs (NSAIDs), rest, ice, compression and elevation (RICE). The report is illegible.

On February 16, 2012, noted that the patient continued to have bilateral radial wrist pain status post repetitive strain injury (RSI). The patient was referred to and was to continue work light duty and limited use of the bilateral upper extremity.

Per utilization review dated May 17, 2012, the request for carpometacarpal (CMC) steroid injection was approved. It was noted that the patient had received bilateral de Quervain injections on the last visit and was provided neoprene braces.

On May 17, 2012, performed a peer review and rendered the following opinions: (1) Based on the data provided the diagnosis of de Quervain's secondary to the work injury. However, the diagnosis of diabetes mellitus, hyperthyroidism, subchondral cyst/erosions over the lunate, capitate and trapezoid on the left, ganglion cyst on the left and right and osteoarthritis on the right were not secondary to the work injury. The patient had a lack of work-up for her ongoing metabolic condition. Further treatment would include medical management and finishing the course of PT. Upon completion of PT, the patient's injury should have resolved.

Following treatment history is available in the peer review:

*On January 17, 2012, evaluated the patient for hand pain, wrist pain and hand swelling. The claimant reported that she had worked for 13 hours yesterday. She developed pain in both hands. She reported she had a similar episode about a year ago. She had not seen her physician for this. History was positive for type 2 diabetes and hyperthyroidism. Examination showed soft tissue swelling crisply over the dorsum of the right hand and wrist. The left hand had minimal soft tissue swelling and had good range of motion (ROM). X-rays of the left and right wrist showed no fractures or dislocations. Occult fractures could not be ruled out. Assessment was bilateral wrist tendonitis. She was treated with Lodine, Lortab, intramuscular (IM) injection of Decadron and Toradol and placed on light duty restrictions.*

*On January 26, 2012, the patient reported pain in both hands, however that her pain had improved. She had pain with range of motion (ROM) at the wrists and fingers. She was given IM injection of Decadron, was maintained on light duty with restrictions and was to continue using nonsteroidal anti-inflammatory drugs (NSAID) and PT.*

On January 30, 2012, x-rays of the bilateral wrists and bilateral elbows were unremarkable.

On January 30, 2012, noted that the patient was working and wearing latex gloves. She started feeling pain in the bilateral hands and wrists. At the end of work day she could not move her fingers and her bilateral wrists/hands were swollen. When she went to work the next day, her employer sent her to clinic. She was evaluated at xxxxx xxx xxxxx, where he took x-rays and prescribed her medications. She was prescribed hydrocodone 5/500 mg and etodolac 400 mg. She was returned to work and she attempted to work but employer could not accommodate light duty. She followed up again at the clinic where they gave her a pain injection. She states ongoing bilateral wrist, hand and elbow pain, numbness and tingling referred to her bilateral hands. She reported that hydrocodone and etodolac upset her stomach. The patient was recommended to discontinue them. Examination of the left wrist revealed decreased ROM, tenderness, positive Phalen's test, Finkelstein sign, and decreased sensation of the left hand. Examination of the right wrist revealed tenderness, decreased ROM, positive Phalen's test and Finkelstein sign, decreased sensation in the right hand and weakness of the bilateral grip strength. Examination of right elbow revealed tenderness, decreased ROM and weakness. Examination of the left elbow revealed tenderness of the elbow joint, decreased ROM and weakness. Initial diagnosis was internal derangement of the bilateral wrists, bilateral elbow sprain/strain, rule out bilateral carpal tunnel syndrome (CTS), bilateral wrist sprain/strain and bilateral hand sprain/strain. The patient was referred to PT, electromyography/nerve conduction velocity (EMG/NCV) of the upper extremities, x-rays of the bilateral elbows and wrists. She was prescribed Medrol Dosepak and naproxen and was placed off work.

From February 8, 2012, through March 5, 2012, the patient attended nine sessions of PT. On February 29, 2012, evaluated the patient for pain and swelling to both wrists, left worse than the right, with repetitious movement of packing and unpacking cheesecakes. She was seen by company doctor who obtained bilateral x-rays of wrist and noted it normal and gave her two-cortisone injection but did not help. Her pain increased with her activity. She was unable to make a fist without having pain or grasp items. She had bilateral wrist pain located on the volar and dorsal aspects of the wrist, with the left side affected more than right. Examination showed positive Finkelstein's test bilaterally and positive bilaterally for first dorsal compartment. The exam was consistent with bilateral moderate de Quervain's disease. Bilateral first compartment injections were given with improvement noted in the Finkelstein's. The patient was provided neoprene splints and recommended formal therapy and motion.

On March 28, 2012, magnetic resonance imaging (MRI) of the left wrist showed few subchondral cysts/erosions over the lunate, capitate and trapezoid. A possible tear of the TFC involving the proximal articular surface was noted. Lobulated cystic lesions was noted, one each on the volar aspect of the wrist joint medially and laterally, likely a ganglion cyst.

MRI of the right wrist showed a lobulated cyst in relation to the pisotriquetral joint, possibly osteoarthritic, a possible tear of the triangular fibrocartilage involving the proximal articular surface.

On April 4, 2012, noted pain in both wrists with tingling sensation that radiated to both radial forearms. The exam today notes her Finkelstein's were negative bilaterally but her left has moderate left basilar thumb carpometacarpal (CMC) joints grind and tenderness and mild on the right. Her grip was weak. Plain films of the left thumb CMCJ showed mild but early signs of loss of joint space and sclerosis of the CMCJ space. A left CMGJ injection was given and post-injection exam noted improvement of the pain. The patient was to continue use of the splint and NSAID. The claimant was taken off work through April 30, 2012.

On May 18, 2012, noted that the patient was status post triangular fibrocartilage complex (TFCC) tear. It was noted that she had injection in the first compartment with mild relief. The orthopedic surgeon had recommended surgical release. It was noted that PT was denied. MRI had shown questionable TFCC tear. recommended light duty.

On June 6, 2012, performed an impairment rating (IR) evaluated and opined that the patient had not reached clinical maximum medical improvement (MMI). The patient had exhausted conservative management and per ODG guidelines further invasive therapeutic options were indicated.

On June 15, 2012, evaluated the patient for increased pain and occasional numbness in her right thumb with night awakening from the right wrist. It was noted that the patient was eight days post a left compartment release and was doing well. Her left wrist pain had resolved. She was currently off work. Examination showed grip strength on the left as five pounds and on the right as two pounds. Right wrist showed dry and clean postop incision. The provocative test was positive for grind on the right side. Tests were positive for TMC on the right side. Compression test were positive for carpal on the right. Percussion test was positive for carpal on the right. assessed bilateral carpal tunnel syndrome (CTS) and bilateral thumb de Quervain's. recommended therapy for the left and a right ECTR and first compartment release as the patient had worsened since her injections.

On July 2, 2012, noted that the patient had mild right-sided symptoms that increased with use. Examination of the left wrist showed a surgical scar. Examination of the right wrist showed a positive Tinel's and positive Finklestein's test. Diagnosis was de Quervain's. The report is illegible.

On July 19, 2012, noted that the patient had 10 sessions of postop therapy with excellent outcome. The patient had right-sided signs and symptoms and was pending surgery. Examination of the right wrist showed tenderness. recommended follow-up with orthopedics.

On August 2, 2012, noted that the patient was unable to grip well, had tingling up to the elbow and a positive Finkelstein's and Tinel's. There was dysesthesia noted in the median distribution. Grip strength was decreased on the right hand. recommended electromyography/ nerve conduction velocity (EMG/NCV) study of the upper extremities. It was noted that the patient had completed PT and had excellent outcome. She continued to have consistent/progressive right upper extremity symptoms.

On August 27, 2012, it was noted that the patient was waiting for repeat EMG postoperatively. The patient had pain in the right lateral aspect of the wrist which was going up midway the forearm. Right hand grip was 3.5/5 and minimal tenderness. recommended EMG.

On September 13, 2012, noted that the patient was pending surgery. assessed right de Quervain's and recommended follow-up after ten days postoperatively.

Per utilization review dated September 13, 2012, the request for arthrocentesis aspiration and/or injection small joint or bursa was approved.

On October 1, 2012, noted that the patient was status post first compartment release of the right. She had mild right hand wrist pain managed by pain medications. Examination of the upper extremity showed a surgical scar over radial aspect of the right wrist. recommended a full range of motion.

Per daily progress note dated November 1, 2012, it was noted that the patient continued to have right wrist pain. She had difficulty holding things. She was treated with therapeutic exercise, manual therapy and myofascial release/massage.

On November 12, 2012, performed a designated doctor evaluation (DDE) and opined that the patient was not at maximum medical improvement (MMI). He believed the patient required a redo of the surgery. She might reach MMI on or about March 1, 2013. The patient could return to sedentary work if available.

On November 19, 2012, the patient underwent a functional capacity evaluation (FCE). The evaluator noted that the patient had moderate-to-severe pain that precluded many activities of daily living (ADLs) and work activities. She demonstrated the ability to safely and dependably perform at a light duty physical demand level (PDL), which failed to meet the minimum job requirement of medium PDL. The evaluator opined the patient would benefit from further medical intervention and she would be a good candidate for a comprehensive chronic pain management program (CPMP).

On November 28, 2012, a clinical psychologist, performed a psychological evaluation. The Beck Depression Index-II (BDI-II) score was 19 which indicated mild depression and the Beck Anxiety Inventory (BAI) score was 37 indicating severe anxiety. The Oswestry Index was 36/100 which indicated that the patient was in the moderately disabled range. The Fear Avoidance Beliefs Questionnaire (FABQ) score was 23/24 which indicated a severe level of fear and avoidance beliefs about physical activity, and 42/42 indicating a severe level of fear and avoidance about work activities. The BPI score was 48 which indicated pain impinging with ADLs on a severe level. It was noted that the patient had undergone conservative measures such as oral pharmacotherapy in conjunction with transcutaneous electrical nerve stimulation (TENS) unit treatment, 24 sessions of rehabilitation efforts, left wrist surgery on June 7, 2012, and right wrist surgery on September 19, 2012, with marginal improvement followed by plateau. Diagnosis was pain disorder associated with both psychological factors and general medical condition. It was opined that she was an appropriate candidate for participation in a work hardening program (WHP). Recommendation was made for a trial of 10 sessions of treatment in a WHP.

On November 29, 2012, evaluated the patient. The patient was two months post a right first compartment release. She was treated with Celebrex that helped and home exercise program (HEP) with no noted improvement. She was denied further physical therapy (PT) and her last therapy session was three weeks ago. She had attended a designated doctor evaluation (DDE) on November 12, 2012, that determined that she was not at MMI and if she required a re-do surgery then she might reach MMI on or about March 1, 2013. She could return to sedentary work if available. She reported mild pain with flexion of the wrist and weakness. She also had pain located on the entire right extremity that occurred with activity predominantly during the daytime. She had undergone x-rays and magnetic resonance imaging (MRI). Examination of the right wrist showed negative Finkelstein's test but still mild tenderness over the operative site and weak grip. assessed bilateral carpal tunnel syndrome (CTS) and bilateral de Quervain's and thumb disorders, prescribed Voltaren cream and Celebrex, and recommended therapy for strengthening. The patient also had residual soreness.

Per utilization review dated December 4, 2012, the request for 80 hours of work hardening was denied with the following rationale: *"Recommend adverse determination. There are multiple items that need to be addressed further. The right wrist AROM and grip are very poor. This is three months after a rather minor surgical procedure and a comprehensive course of post-op rehab. The treating orthopedist needs to address this issue and provide, in writing, his assessment and plan of care that specifically needs to account for such poor right upper extremity function. In addition, there is documentation that the right wrist surgery did not alleviate pain symptoms and has resulted in high pain levels. This needs to be assessed and addressed. In addition, these are the same providers who performed the post-op rehab after both operative procedures. The same providers document marginal improvement post-op and after the supervised rehab completed. It is not clear and not documented how a tertiary rehab program by the same providers is reasonably expected to be any more effective than previously performed and completed rehab. Essentially, there is no explanation how more of the same and the same rehab facility by the same rehab providers is reasonably expected to lead to a different outcome than the previously unsuccessful post-op rehab especially as it pertains to the right upper extremity. I spoke with and the case was discussed. I voiced my concerns to him. He told me that he will obtain documentation from the office of regarding the current issues revolving around the right wrist."*

On December 14, 2012, evaluated the patient. Following treatment history was obtained: *On October 30, 2012, the patient was seen. The patient was six weeks post a right first compartment release while still treating with therapy. Examination showed healed wound and negative Finkelstein's test. The ROM had improved but grip strength was still weak. recommended strengthening and felt that the patient should be ready to return to work. noted hyperesthesia over the surgical scar in the right hand, 2+ deep tendon reflexes (DTR), and diminished grip/pinch strength in the right versus the left hand and recommended that the patient should be progressed into work hardening. recommended 10 sessions of WHP.*

On December 27, 2012, noted that the patient's Voltaren cream and therapy had been denied. The patient was doing HEP that had resulted in no change in symptoms. She had minimal pain, numbness, tingling, stiffness and moderate weakness with activity such as twisting of wrist or cold temperature. She was off work. Examination showed a negative Finkelstein's, no tenderness and a weak grip. He opined that the patient was approaching MMI but would benefit with a strengthening program and recommended follow-up with treating doctor for reconsideration of therapy, if not considering an HEP and then an impairment rating. prescribed therapy.

Per reconsideration review dated December 19, 2012, the request 80 hours of work hardening was denied with the following rationale: *"I spoke with on December 27, 2012, at 5:00PM CT. He stated that the claimant was seen today and he did not feel that additional surgery was necessary. stated that he would fax that office note to my attention. I received a clinical note dated December 27, 2012, and this was reviewed. noted that the claimant had minimal pain, negative Finkelstein, no tenderness and a weak grip. He recommended a strengthening program and prescribed therapy three times a week for four weeks. Recommend adverse determination. There is some issue whether the claimant provided full voluntary effort on the FCE in light of the lack of a bell-shaped curve and high coefficient of variation on grip strength testing. did not specifically recommend work hardening, he recommended additional physical therapy for strengthening. Lastly, the claimant does not have a job to return to and according to the November 28, 2012, report, the claimant wanted to return to school and enroll in a veterinary program. It is not clear that work hardening would be necessary"*

On January 2, 2013, noted that a reconsideration request was denied. She recommended 10 sessions of WHP.

On January 7, 2013, noted that the patient had fair outcome of the surgery on the right wrist. She had mildly decreased wrist flexion on the right and negative Tinel's. She had numbness and tingling of the first and second digit of the right hand. She had mild grip/pinch loss as well as decreased opposition on the right than left. The report is incomplete.

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

Work hardening is needed when there is significant deconditioning and wrist or hand injury would not cause generalized deconditioning and should not be necessary. ODG states: There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip, knee, shoulder and forearm.

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

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

