

Independent Reviewers of Texas  
4100 West Eldorado Pkwy #100-373  
McKinney TX 75070  
[independentreviewers@hotmail.com](mailto:independentreviewers@hotmail.com)  
Phone: 469-218-1010  
Fax#: 469-374-5862

Notice of Independent Review Decision

[Date notice sent to all parties]:

07/12/2013

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 80 Appeal of 80 hours of work hardening program for the left shoulder, as an outpatient.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** Board Certified Family Practice Physician

**REVIEW OUTCOME:**

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

Upheld (Agree)

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:**

01/28/2013, Functional Capacity Assessment Functional Testing, no credentials given. 02/19/2013, MRI report, left shoulder,. 03/28/2013, progress note. 04/18/2013, progress note. 05/01/2013, progress note. 05/06/2013, Functional Capacity Assessment, Functional Testing, no credentials given. 05/08/2013, progress note. 05/08/2013, order for work hardening versus CPM, no stated provider. 05/16/2013, behavioral evaluation report. 05/23/2013, pre-authorization request for work hardening program. 06/06/2013, request for reconsideration. 06/26/2013, correspondence. 05/30/2013, initial utilization review determination. 06/17/2013, appeal utilization review determination.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

**This claimant is a male with reported date of injury of xx/xx/xx.**

**On 01/28/2013 Functional Capacity Assessment was performed at Functional Testing. It was noted at the FCE and according to the evaluation he was performing at a sedentary to light PDL at that time, which indicated a mild functional deficit.**

**On 02/19/2013 MRI of the left shoulder was obtained, which revealed moderate strain of the distal supraspinatus and infraspinatus tendons with a partial-thickness tear of the distal infraspinatus tendon without retraction or a full-thickness tear being identified. There was a widened rotator cuff interval, along with moderate joint effusion, and mild glenohumeral arthritic changes noted on this exam.**

**He returned to clinic on 03/28/2013 with evaluation. He continued to report shoulder discomfort and reported physical therapy had provided minimal improvement and symptoms had still been rated as severe. He had a positive Neer and Hawkins impingement sign at that time and had subacromial tenderness. Rotator cuff strength was 5/5 and motion was full, but he was tender over the subacromial space. He was getting a steroid injection at that time to the left shoulder.**

**He returned on 04/18/2013 with further evaluation. and stated that he was doing better with the last injection, but still not at 100%. He still had a positive Neer and Hawkins sign and subacromial tenderness was noted. He did have good strength.**

**On 05/01/2013 he was seen. On exam he had restricted abduction rated at 120 degrees with pain, restricted flexion rated at 115 degrees, and 4/5 power to the infraspinatus and supraspinatus muscles on the left. He was given a 0% impairment rating previously and he was referred for an FCE.**

**On 05/06/2013 a Functional Capacity Evaluation was performed at Functional Testing. He was performing at a light to medium PDL at that time.**

**On 05/08/2013 he returned and examination was essentially unchanged and pain was rated at 5/10 at that time. He received therapeutic exercises at that time.**

**On 05/16/2013 a variable evaluation was submitted indicating that he had depression related symptoms that appeared to meet criteria for clinical significant distress with impairment of his independent and occupational capabilities. Diagnosis included pain disorder associated with psychological factors and adjustment reaction with anxiety.**

**On 05/23/2013 a request for work hardening was submitted.**

**On 06/06/2013 a request for reconsideration was submitted. On 06/26/2013 a letter was submitted in support of the request for work hardening program.**

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

On 05/30/2013 the initial determination was that the work hardening request was non-certified. The rationale given at that time indicated the records reflected that there had been some conservative treatment, but this was not well delineated. There were no prior treatment records or physical therapy progress reports provided for that review. Pain is rated at 4/10 and the Beck Depression Inventory-II score of 17 and the Beck Anxiety Inventory of 14 were reviewed. As such, the request was non-certified. A subsequent review on 06/17/2013 also determined that the requested work hardening was non-certified. Rationale given was that it was noted that he had responded to conservative measures and his current PDL was medium. There was no clear clinical indication for such an intensive protocol to regain functionality from medium to heavy. Furthermore, it was noted there was no clear clinical indication for a multidisciplinary approach to gaining those goals. A specific return to work plan was not documented, and therefore, there was no clear clinical indication for work hardening program at that time. The additional records provided for this review also indicate that he had a Functional Capacity Evaluation on 05/06/2013 which revealed he was at a light to medium PDL. He was able to abduct the left shoulder to 120 degrees and flex to 115 degrees as of 05/08/2013. Physical therapy notes were not provided for this review to document that he had any significant conservative care, although it was discussed that he had conservative care. Guidelines state "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." The specific job return to work program had not been outlined by the records provided for this review and guidelines state for work hardening to be appropriate "A specific defined return-to-work goal or job plan has been established, communicated and documented." Therefore, the initial determination and subsequent determination are upheld and the request is non-certified.

ODG, shoulder chapter, online version

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. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing 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.

(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 be 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.

(15) Concurrently working: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.

(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.

(18) Post-injury cap: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs).

(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.

(20) Discharge documentation: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.

(21) Repetition: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

## IRO REVIEWER REPORT TEMPLATE -WC

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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