

CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

September 19, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening/work conditioning program 10 sessions

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 (08/08/13)
- DWC-73 (08/08/13)
- Utilization review (08/28/13)

- Utilization review (08/28/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was injured at work on xx/xx/xx. She suddenly felt a pop in the region of the right elbow, as a result of which she developed severe pain and loss of function.

On August 8, 2013, evaluated the patient for pain and loss of function in her upper extremity. She had been treated on a conservative basis for a period of time with

therapy and medication with continued impaired disability. She also underwent two surgeries to the elbow along with frequent injections into the elbow area with very guarded results. She was presently doing light duty only. She stated that she experienced severe pain without any activity; however, it was grossly aggravated certainly with activities. The persistence of pain had caused the patient to suffer depression as well as some sleep disturbance. She was willing to return to a normal status so that she could return to work under current full-time work without any limitations or problems. Her current medications included Lyrica, ibuprofen, Cymbalta and cyclobenzaprine. She had difficulty with most activities involving the right upper extremity. Certainly, she could not do any lifting above the shoulder level. She had grossly decreased strength in that arm and it was also associated with spontaneous disabling pain which prevented her from pursuing any work using the right upper extremity to any degree. Examination showed some swelling of the lower extremities and stiffness of the elbow, wrist and finger joints. There was disturbance in the hair pattern growth of the right arm. On palpation of the lower arm, the burning pain of the extremities was aggravated and the patient demonstrated both allodynia and hyperpathia. Examination of the cervical spine showed severe reproducible pain and discomfort in the right intertransverse region of C5-C7. There was some lateralization of the pain extending from the spine to the right shoulder area. There was also associated pain in the right elbow area and evidence of well-healed surgical scars. There was definite allodynia and hyperesthesia on examination. Cervical spine range of motion (ROM) was decreased due to pain in the right C5-C7 region. The most severe pain reproduction occurred with lateral flexion to the left costal traction in that area. ROM of the elbow was decreased because of the intensity of the pain. There was decreased grasping strength in the right hand. It was associated with weakness of the flexor, extensors, abductors, adductors, pronators and supinators. Pinwheel revealed decreased sensorium in the right hand compared to the left. Measurements of the right arm taken at the area 10.0 cm above and below the olecranon revealed measurements at 30.0 and 24.0 cm respectively as compared to the left side at 29.0 and 23.0 cm. diagnosed status post right epicondyle surgery, sympathetic-median pain and right upper extremity pain associated with discogenic disease. He recommended a work hardening program (WHP) for the fact that the patient had so many restrictions which limited her workability and with the participation in a WHP she could possibly improve her status and seek employment on a full-time basis. Magnetic resonance imaging (MRI) of the cervical spine should also be carried out to rule out any pathophysiological process which might be causing the loss of function and nerve pain in the right upper extremity. The other possibility would be to do a ganglion block which would help determine whether the pain was sympathetically-mediated and ultimately could address a treatment more specifically to improve her status and ability to return to regular duty. This patient was at maximum medical improvement (MMI), however, under the Compensation Law, she was entitled to treatment and medical consultation for the rest of her life as this could alleviate or cure her symptoms. also referred the patient for functional capacity evaluation (FCE).

On August 8, 2013, performed a psychological interview for evaluation to help develop rehabilitation pain management and medical plans and to possibly assume treating doctor status. The patient reported that her pain level was presently always at five and sometimes if flared up more than that. She had significant pain in the right side of her neck through her right shoulder into her right arm and all the way into her hand. She reported that she struggled with depression. She stated that the depression was always there. Her Beck Depression Inventory II (BDI-II) score was 27, her Beck Anxiety Inventory (BAI) score was 30 and her PA score was 14. Diagnosis was pain disorder associated with psychological factors and general medical condition, chronic pain status post shoulder and right arm injury with two surgeries on the right elbow and surgery on the shoulder offered, but not pursued and chronic pain, disruption of activities of daily living (ADLs), some disruption of work and limitations of work, some financial stress. The Global Assessment of Functioning (GAF) score was 59 currently. Ms. referred the patient to the medical and physical therapy (PT) evaluation for details. The patient was appropriate by the Official Disability Guidelines (ODGs) for treatment in a WHP. Though she was working, she had limitations which were limiting her ability to actually work full-time. She also had some depression and anxiety that was directly related to her injury and the resulting pain and disruption of her life and fear of her future.

On August 20, 2013, there was a pre-authorization request sent for work hardening.

Per utilization review dated August 28, 2013, the request for ten sessions of WCP was denied based on the following rationale: *"In this case, the injured worker has been retrained and is working. It is also noted injured worker has already completed a chronic pain management program. Further injured worker suffers mild impairment that is not related to deconditioning but to chronic pain related to prior surgery. Functionality limited by this pain is unlikely to change with work hardening. Further present functional deficits are unclear since there is no FCE or present job description to review with details as to essential job function. ODG notes that work conditioning/work hardening is to recondition an injured worker after an absence from work for the specific demands of the job. ODG notes that when injured worker is stable from injury if he remains deconditioned and cannot perform the essential job functions of own occupation, then work conditioning/work hardening is both reasonable and necessary. In order to determine this impairment related to deconditioning, a job description is needed and an FCE is needed. Neither is available at this time. This modality is not meant to return injured worker to pre-injury level of functioning or to treat underlying or injury-related impairments. Work conditioning/work hardening is meant to address deconditioning related to inactivity in order to return injured worker to own occupation performing essential job functions of his own occupation. Based on available medical data and without a recent FCE or an appropriate job description, there are insufficient indications for request after 10 years and working. I spoke with peer contact. No FCE and no job description with essential job functions are available to review. He was unaware of chronic pain program in 2006. No recent history of therapy noted either. Based on*

information provided, he agrees with present recommendation of non-authorization.”

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

This individual was injured in xxxx and based on the records the injury is to the elbow, which should result in generalized deconditioning. Work conditioning/work hardening is meant to address deconditioning related to inactivity in order to return injured worker to own occupation performing essential job functions of his own occupation. In addition, he participated in a comprehensive pain management program in 2006 and Work hardening should not be necessary. The records received did not include a recent FCE or history of recent physical therapy.

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