

IRO NOTICE OF DECISION – WC



Notice of Independent Review Decision

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August 14, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 Hours (10 sessions) of work hardening program with psychological reassessment and FCE at completion of 10 days

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

Doctor of Chiropractic

REVIEW OUTCOME:

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 medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

7-10-13, the claimant reports right arm/hand symptoms. She complains of intermittent right arm pain, right shoulder, right elbow, and right wrist pain that she rates a 7/10. Exam shows right shoulder ROM decreased with pain in all planes. Positive Neer. Painful abduction are from 90 to 145. TTP of right rotator cuff region and AC joint. Right ROM with pain. TTP over medial epicondyle. Right wrist ROM decreased with pain in all planes. Positive Tinel's and Phalen's. TTP of wrist. Impression: Right upper extremity injury. Right elbow medial epicondylitis. Right carpal tunnel syndrome. Right shoulder impingement syndrome. Plan: Referral for upper extremity EMG/NCV and medication management. Referral for 6 PMR sessions. Consider referral to ortho pending results. Modified duty.

7-24-13, the claimant complains of intermittent right arm pain, right shoulder, right elbow and right wrist pain that she rates a 7/10. Plan: Refer for UE EMG/NCV and medication management. Pending referral for 6 PMR sessions. Consider referral to orthopedic specialist pending results. Modified duty.

7-29-13, the claimant has a chief complaint of shoulder, elbow, and wrist/hand. Exam shows 5-/5 motor. Positive Tinel's and Phalen's. Impression: Shoulder sprain. Impingement. CTS. Hand written illegible notes. Plan: Motrin and Robaxin.

8-22-13, the claimant reports decreased right shoulder pain but complains of intermittent right arm pain, right elbow and right wrist pain that she rates a 7/10. Plan: Reviewed UE EMG/NCV findings. Refer. Pending referral for 6 PMR sessions. Modified duty.

8-22-13 EMG/NCV, showed right radial tunnel.

Physical therapy on 9-5-13, 9-9-13, 9-11-13, 9-13-13, 9-16-13, 9-18-13, 11-21-13, 12-3-13, 12-6-13, 12-12-13, 12-17-13, 12-27-13, 1-22-14, 2-12-14, 2-21-14, 2-24-14, 2-25-14, 3-31-14, 4-9-14, 4-17-14, and 4-23-14.

9-13-13, the claimant reports much increased right forearm pain, right elbow and right wrist pain that she rates an 8-9/10. Plan: Refer. Complete 6 PMP sessions. Modified duty.

9-25-13, the claimant complains of constant right forearm pain, right elbow and right wrist pain that she rates a 7/10. Plan: Pending referral to ortho consult. RTC 1 month. Modified duty.

10-7-13, the claimant presents for right wrist pain and limited function that she rates a 9/10. Exam shows right wrist TTP of 1st dorsal extensor tendons. Positive Finkelstein. Mild radial sided wrist swelling. Tenderness at the lateral epicondyle. Lateral elbow pain with resisted wrist dorsiflexion. Diagnosis: Radial styloid tenosynovitis. Synovitis unspecified. Enctr therap drug monitor. Plan: Right wrist

injection given. Right thumb/hand/wrist/distal forearm rigid removable orthosis is applied. Mobic 15 mg. Use wrist brace. Right wrist MRI. RTC 2-3 weeks.

10-11-13 MRI of the right wrist, showed central defects of the scapholunate ligament, lunotriquetral ligament and body of the triangular fibrocartilage. Nonspecific mild tenosynovitis of extensor and flexor tendon sheaths.

10-21-13, the claimant presents for right wrist pain and limited function that she rates a 9/10. Plan: She will benefit from surgical release of right wrist 1st dorsal compartment. Mobic 15 mg. Continue wrist brace.

10-25-13, the claimant denies any improvement with injection. She complains of right forearm pain, right elbow and right wrist pain that she rates an 8/10. Plan: Pending authorization for requested surgery to be performed. Post-surgical rehabilitation. RTC 1 month. Modified duty.

11-11-13, the claimant presents for postop follow up. Pain is well controlled. Plan: Apply forearm splint. She will benefit from right hand/wrist therapy. Motrin 400 mg. Keep operative site elevated. RTC 1 week for suture removal.

11-14-13, the claimant complains of intermittent right forearm pain, right elbow and right wrist pain that she rates an 8/10. Plan: Referral for 10 post-surgical rehabilitation sessions. RTC 3 weeks. Off work.

12-11-13, the claimant presents for postop follow up. Pain is well controlled. Exam shows mild wrist tenderness/swelling. Positive hand/wrist stiffness. Impression: Improving postop. Plan: Pain management as needed, Motrin. Use compound cream. Complete therapy. RTC 1 month.

12-12-13, the claimant complains of intermittent right forearm pain, right elbow and right wrist pain that she rates an 8/10. Plan: Complete post-surgical rehabilitation. RTC 2 weeks. Off work.

12-27-13, the claimant complains of intermittent right forearm pain, right elbow and right wrist pain that she rates a 7-8/10. Exam shows right elbow ROM with pain. TTP over medial and lateral epicondyle. TTP over wrist dorsiflexors. Right wrist ROM reduced with pain. TTP along base of thumb and along incision site. Impression: Right upper extremity injury. Radial styloid tenosynovitis. Central defects of the scapholunate ligament, lunotriquetral ligament and body of triangular fibrocartilage per MRI. Right elbow medial/lateral epicondylitis. Right radial tunnel. Plan: Referral for additional 6 PMR sessions. Follow up. RTC 3-4 weeks.

1-20-14, the claimant continues to have difficulty holding items with right hand. Plan: Complete additional 6 PMP sessions. Follow up. RTC 3-4 weeks. Refer for FCE. Modified duty.

2-17-14, the claimant complains of intermittent right forearm pain, right elbow and right wrist pain that she rates an 8-9/10. Plan: Authorize additional 6 PMR sessions. Follow up. RTC 3-4 weeks. Modified duty.

Mental health re-evaluation on 2-19-14.

3-10-14, the claimant presents for postop follow up. She still complains of right wrist pain. Exam shows extensor compartment wrist tenderness/swelling. Mild hand/wrist stiffness. Mild TFCC tenderness.

3-18-14, the claimant reports that right wrist pain comes and goes with physical activity. She also reports continued weakness in grip strength. She completed surgical release of right wrist 1st dorsal compartment on 11-7-13. She complains of intermittent right forearm pain, right elbow and right wrist pain that she rates an 8/10. Exam shows right elbow ROM mildly reduced in flexion with pain. TTP over medial and lateral epicondyle and over wrist dorsiflexors. Right wrist ROM mildly reduced with pain. Positive Finkelsteins. TTP along base of thumb and along incision site. Impression: Right upper extremity injury. Radial styloid tenosynovitis. Central defects of the scapholunate ligament, lunotriquetral ligament and body of triangular fibrocartilage per MRI. Right elbow medial/lateral epicondylitis. Right radial tunnel. Plan: Referral for additional 4 PM sessions. Refer for FCE. See PCP for elevated BP and get a refill on her thyroid medication. Modified duty.

Physical medicine and rehabilitation request on 3-20-14.

3-31-14, the claimant complains of intermittent right forearm pain, right elbow and right wrist pain that she rates a 9/10. Plan: Complete authorized additional 4 PMR sessions. FCE next week. See PCP for her elevated BP and get a refill on her thyroid medication. Modified duty.

4-9-14 FCE shows the claimant is functioning at a Sedentary to Sedentary-Light PDL.

4-11-14, notes the claimant is a good candidate for a work hardening program.

4-23-14, the claimant complains of intermittent right forearm pain, right elbow and right wrist pain that she rates a 7/10. Plan: Therapy given.

4-29-14 notes that based on the medical records submitted for review on the above referenced claimant, 80 additional hours of WH is not approved. Claimant has had 16 PT sessions. Claimant does not meet ODG (Official Disability Guidelines) criteria #9 and #4. She is no longer employed by the same employer. She has been approved for 6 individual sessions of psychological counseling. 03/31/14 Rehab notes noted she has been approved for additional PT. Right wrist tenosynovitis is still symptomatic. Medications: Lisinopril, levothyroxine, vitamin D, out of PCP prescription and has lost health insurance. Motrin (twice per day), Robaxin 750mg

once a day. Seeing. Well healed surgical scars of Left and Right wrist and Left elbow.

Work hardening program pre-authorization request on 5-26-14.

6-12-14 notes Chiropractor has non-authorized reconsideration for 80 Hours (10 Sessions) of Work Hardening Program with Psychological Reassessment and FCE at completion of 10 days as not medically necessary.

Notice to utilization review agent of assignment to IRO on 7-28-14.

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

Review of the documents shows the claimant has had at least 16 sessions of physical therapy and appears to have been authorized 9 sessions of individual psychotherapy. Incremental assessment of the claimant's abilities for her activities of daily living (ADLs), categorized as "Functional Areas," seem to show a progression of improvement during the post-operative period, beginning at a score of 14 shortly after surgery and ending at a score of 33 on 04/17/14. However, there is mismatch between this reported improvement and the claimant's performance on the Functional Capacity Evaluation one week prior, on 04/09/14, in which the claimant demonstrated minimal functional abilities in nearly all testing requiring hands and arms. This inconsistency suggests that the conclusion that the claimant can only perform at the sedentary-sedentary light physical demand level (PDL) may be inaccurate.

Should the demonstrated abilities be accurate, the difference between the claimant's performance and the required abilities to reach a medium PDL is vast, requiring the claimant to increase her capacity by about 500% for nearly every function in 10 to 20 days of a program. Given the inability to progress adequately after 5 months of physical therapy and at least 16 sessions, there is little expectation of a successful outcome of a work hardening program.

With regard to the psychological aspect of the program, the claimant was authorized 6 post-operative individual therapy sessions sometime after February 2014. As of 04/11/14, the claimant had completed 3 sessions with "improvement with symptoms." The outcome of these 6 sessions remains unknown and there is no subsequent comparative testing reported of Beck Depression or Anxiety inventories or rehabilitation questionnaires.

Additionally, there is no specific job noted for which to target the work hardening program.

Therefore, given these factors, 80 hours (10 sessions) of a work hardening program with psychological reassessment and FCE at the completion of 10 days is not medically necessary.

ODG 2914 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.

A 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)**