

# CASEREVIEW

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Notice of Independent Review Decision

**September 8, 2015**

**IRO CASE #:**

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

Work Hardening Program, 80 Hours, related to the left shoulder injury, as an outpatient

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 17 years of experience.

**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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained injuries on xx/xx/xx while attempting to lift a x weighing approximately 65 pounds overhead with coworkers. During the lift he had a sudden onset of left shoulder pain and was immediately taken to a local workers' compensation medical clinic for evaluation and x-rays. He underwent a course of physical therapy (6 sessions) and his pain resolved and was doing well until November of 2014. At that time he was using a sledge hammer and begun to feel the same pain in his left shoulder. He underwent a MRI of the left shoulder on November 26, 2014, FCE on March 27, 2015, Arthrogram/MRI on June 16, 2015. It was also noted that recommended physical therapy 3 times per week for 4 week on June 18, 2015, but the request was denied. On July 8, 2015, the claimant had a consultation with orthopedic specialist, who recommended an EMG/NCV to assess nerve damage/entrapment as well as surgery on the injured shoulder. However, the claimant wishes to exhaust other options prior to having surgery.

On July 10, 2015, the claimant presented with left shoulder pain. It was reported that the MRI on November 26, 2014 revealed: 1. Mild supraspinatus tendinitis. No convincing rotator cuff tendon tear is identified. 2. Mild degenerative changes of the a.c. joint. 3. Trace fluid within the soap acromial subdeltoid bursa which could be sequel of mild bursitis. It was also reported that the MRI arthrogram on June 16, 2015 revealed: 1. Abnormal signal in the mild tendinous junction of the supraspinatus and infraspinatus tendons consistent with partial tears or strains. 2. Subacromial bursitis. 3. Acromioclavicular joint osteoarthritis. On physical examination the left shoulder was noted for no evidence of any deformity, no edema, and no discoloration. There was decreased

active ROM of the left arm at the shoulder joint due to pain. There was mild tenderness to palpation over the soft tissue structures of the shoulder girdle. Otherwise was neurovascularly intact. Impression: Left shoulder sprain strain, cannot rule out more disease. Plan: UDS ordered. Cleared for WHP. Work Hardening Program ordered. FCE ordered.

On July 22, 2015, the claimant presented to Melody Libby, LPC to assess his emotional status and to determine the relationship to the work incident. Current Medications: Ibuprofen 800 mg, Lisinopril 20 mg, and Zetia 10 mg. Pain was described as intermittent dull aches with increments to sharp pain and weakness when lifting. His pain was rated 5/10 with an average pain level ranging from 1-6/10. He reported interference with a wide range of life function including personal, family, social and occupation activities. He reported difficulties with overhead reaching and lifting/carrying objects. Mr. Green rated his level of overall functioning in life prior to the injury at 100% and rates his current level of functioning at 60%. Work: The claimant occupational history includes heavy labor, skilled work, and construction. He is working with light-duty restrictions. He scored a 9 of the BDI-II, indicating minimal depression and a score of 1 on the BAI, reflecting moderate anxiety. He showed significant fear avoidance of work (FABQ-W =29) as well as non-significant fear avoidance of physical activity in general (FABQ-PA=11). Diagnosis: Somatic Symptom Disorder, with predominant pain, persistent, moderate. Recommendations: The patient is an excellent candidate for the Work Hardening Program.

On July 22, 2015, the claimant underwent a FCE. During the interview he reported he was working Full-Time the "same job with same employer". He explained that he was doing the same job and just being cautious and asking for help if he needed it. He had been placed on restriction by the treating doctor. Based on the results, it was recommended that the claimant continue with some form of continued active care to get his area of injury more stable as to avoid further injury or re-injury. Care such as therapeutic exercise, active therapy, or some form of tertiary vocational therapy such as a return to work program was recommended. The claimant's required PDL is Medium (40 pounds), however his current physical performance level was only functioning within the Medium level (25 pounds) but had not satisfied full criteria of the Medium work demand load of 40 pounds per the employer. He was unable to demonstrate the ability to perform several key functions crucial to the safe performance of his normal work duties and therefore should be listed in the Light lifting category.

On July 24, 2015, according to the Pre-Authorization request, the claimant's treating physician recommended that the claimant be progressed to a work hardening program due to the claimant's persistent functional deficits, which were impeding his ability to make a safe return to work on full duty. The claimant had expressed a sincere desire to return to work on full duty. It was reported that the claimant had shown modest improvement with outpatient physical therapy modalities and that's why they were now recommending progression to a Work Hardening Program for continued progress to be achieved.

On July 28, 2015, performed a UR. Rationale for Denial: According to the Official Disability Guidelines, the claimant does not meet criteria for a work hardening program as minimal conservative therapy has been completed and the claimant is a candidate for surgical intervention. As the claimant does not meet the criteria for such a program, 80 hours of a work hardening program are not indicated.

On August 14, 2015, according to the Reconsideration for Work Hardening, in response to the previous denial it was stated that had told the claimant he needed surgery but the claimant does not want surgery and is hoping that exercise will help his pain. He is working full time with restrictions as a mechanic. It was also reported that the claimant is having difficulties with overhead reaching and lifting/carrying objects at work. He noted it was now both difficult and painful for him to work on vehicles or use his left hand. Prior to the injury he noted he was ambidextrous and now he is unable to use his left hand and has had to alter how he does activities. For example, he has had to alter how he works on his vehicles so a job takes him much longer.

On August 18, 2015, UR. Rationale for Denial: There is no reasonable expectation that this claimant will improve with additional work hardening. The claimant has internal derangement of his left shoulder that does require surgery. He has exhausted physical therapy. He has had more than a fair amount of physical therapy since his flare-up in November 2014. There is no reason to expect that he will advance beyond the present level that he is

without surgery. Therefore, the rationale for work hardening is not met as per the ODG Guidelines.

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

Determination: Denial of 80 hours of work hardening is UPHELD/AGREED UPON since there has not been exhaustion of lower levels of care for diagnosis of partial tear of rotator cuff. It is understood there has been completion of only 6 basic PT visits for this injury timed soon after the injury dated 1/13/14 but none since re-aggravation in November of 2014; and a denial for an additional 12 PT visits after that aggravation. ODG shoulder chapter recommends up to 20 basic PT visits for a partial rotator cuff tear. This is particularly pertinent in this case where work hardening has been recommended specifically to avoid surgery. There is NO documentation of range of motion and strength deficits about the affected shoulder or instruction in and compliance with a home exercise program in order to demonstrate exhaustion and plateau with basic physical therapy visits so as to warrant progression to an interdisciplinary work hardening program. Furthermore, there is question as to consideration of other conservative measures such as secondary level NSAIDS (since documentation of only Ibuprofen 800), corticosteroid injection, and gradual lessening of restrictions at work since light duty is currently being accommodated and the gap in functional deficit, between current 25 lb lift and 40 lb requirement, is NOT that significant of a gap to close by this method. Therefore, the request for Work Hardening Program, 80 Hours, related to the left shoulder injury, as an outpatient is not found to be medically necessary at this time.

PER ODG:

**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.

#### **ODG Work Conditioning (WC) Physical Therapy Guidelines**

WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also [Physical therapy](#) for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.

*Timelines*: 10 visits over 4 weeks, equivalent to up to 30 hours.

#### **ODG Physical Therapy Guidelines –**

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

#### **Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):**

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

#### **Complete rupture of rotator cuff (ICD9 727.61; 727.6)**

Post-surgical treatment: 40 visits over 16 weeks

#### **Adhesive capsulitis (IC9 726.0):**

Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 24 visits over 14 weeks

#### **Dislocation of shoulder (ICD9 831):**

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (Bankart): 24 visits over 14 weeks

#### **Acromioclavicular joint dislocation (ICD9 831.04):**

AC separation, type III+: 8 visits over 8 weeks

#### **Sprained shoulder; rotator cuff (ICD9 840; 840.4):**

Medical treatment: 10 visits over 8 weeks

Medical treatment, partial tear: 20 visits over 10 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

#### **Superior glenoid labrum lesion (ICD9 840.7)**

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (labral repair/SLAP lesion): 24 visits over 14 weeks

#### **Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9)**

Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

#### **Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):**

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

**Fracture of clavicle (ICD9 810):**

*8 visits over 10 weeks*

**Fracture of scapula (ICD9 811):**

*8 visits over 10 weeks*

**Fracture of humerus (ICD9 812):**

Medical treatment: 18 visits over 12 weeks

Post-surgical treatment: 24 visits over 14 weeks

**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)**