

Vanguard MedReview, Inc.

4604 Timken Trail
Fort Worth, TX 76137
P 817-751-1632
F 817-632-2619

January 20, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Hardening Program 80 Hours

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

This case was reviewed by a Licensed Chiropractor with over 20 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 to his right shoulder and right on XX/XX/XX when he was at work. He was assisting 3 other fellow workers move a table when he slipped and the table fell on him.

XX/XX/XX: Office Visit. **HPI:** The patient presents today with Rt shoulder/Rt knee injury. Rt shoulder pain no change pain radiates down his arm. R knee getting better pn level 4/10. He states pain med makes him dizzy/nausea. He is not working at this time. S/P right shoulder surgery on XX/XX/XX. Has begun PT. S/P right knee surgery; much improved. Minimal pain. Complaint of shoulder pain. Pain is located in the right anterior shoulder and right lateral shoulder. He describes his pain as sharp in nature and moderate in severity. Symptoms are improving. Associated symptoms include decreased ROM and stiffness, but no numbness in arm and no shoulder bruising. Exacerbating factors include shoulder movement, shoulder rotation and overhead use. Relieving factors include rest, nonsteroidal anti-inflammatory drugs, opioid analgesics and physical therapy. Complaint of rt knee pain. Pain is described as dull and aching and mild. Exacerbating factors include kneeling and squatting. Patient is taking medications as prescribed and is improving and has been referred to PT. He has attended 5 therapy visits since the last visit. Patient is using brace/splint/assistive device as prescribed and is tolerating well and has a relief of pain. **Physical Exam:** Musculoskeletal: Rt shoulder: ROM: limited in all planes and painful in all planes. Rt Knee: medial joint line tenderness. **Assessment:** 1. Internal derangement of knee 2. Shoulder joint derangement. **Plan:** Follow-up 5 weeks, continue pt, continue meds

XX/XX/XX: Office Visit **HPI:** Patient returns for a re-check of injuries. Symptoms are worsening. The pain is located in the posterior neck bilaterally. There is no radiation. Associated symptoms include neck stiffness, but no fever,

no headache, no upper extremity, paresthesias, no upper extremity weakness, no urinary incontinence and no vomiting. Exacerbating factors include neck movement. Relieving factors include nonsteroidal anti-inflammatory drugs. Patient is taking the medications as prescribed and is improving and is tolerating well. Patient has not been working. **Physical Exam:** Right shoulder: ROM: Full except internal rotation is painful. Limited internal rotation. Right Knee: ROM: Pain with squatting. Knee strength was normal bilaterally. Cervical Spine: Right rotation painful. Left rotation: painful. **Assessment:** 1. internal derangement of knee 2. Shoulder joint derangement. **Plan:** Follow-up 3 weeks, continue meds, Return to modified work/activity today.

XX/XX/XX: Office Visit. **HPI:** The patient presents today with RT shoulder pain improving, RT knee no improvement. Patient has completed FCE on Friday. Patient describes the pain as aching and throbbing. He describes this as severe, a current pain level of 8/10. The pain radiates to the right hip and right thigh, unchanged. Associated symptoms: pain in other joints, limping, decreased ROM, stiffness, tenderness and painful walking, but no swelling. Exacerbating factors include knee extension, knee flexion, kneeling, direct pressure, squatting, using stairs, walking and bearing weight. Relieving factors include rest, ice and elevation. **Physical Exam:** Right shoulder: ROM: Full, extension painful. Limited internal rotation ROM. Shoulder strength was normal bilaterally. Right knee: Skin trauma of a lateral scar. Tenderness: diffuse lateral knee. Special Tests: Negative except positive patellar grind and positive Bounce Home test. **Assessment:** 1. Tear of right rotator cuff 2. Internal derangement of knee 3. Right knee sprain 4. Right shoulder tendinitis **Plan:** 1. Work conditioning referral physician referral consult status: Complete Done: XX/XX/XX. Ordered for internal derangement of knee, shoulder joint derangement. 2 hours/day, 5 days a week for 2 weeks total 10 sessions.

XX/XX/XX: History and Physical Work Hardening. **HPI:** Patient sustained injury XX/XX/XX. After multiple evaluations and treatments to include surgical procedures on his right shoulder and right knee, he has been approved for a work conditioning program. However an FCE conducted on XX/XX/XX reports that the patient had a work occupational demand of heavy and is currently at a PDL of medium, thus recommending a work hardening program. A repeat FCE was conducted at the XX on XX/XX/XX. That study reported that the patient has a work occupational demand of heavy and again is at a PDL of medium. A psychological intake and evaluation was conducted on XX/XX/XX which also supported attendance for a work hardening program. The patient will be submitted for a work hardening program. **Physical Exam:** Musculoskeletal: Right shoulder is noted for no evidence of any deformity, no edema, and no discoloration. There is significant decreased active ROM of the right upper extremity at the shoulder joint secondary to pain. There is diffuse mild tenderness to palpation over the soft tissue structures of the right shoulder girdle. Otherwise the patient is neurovascularly intact. The right knee is noted for no evidence of any deformity, no edema, and no discoloration. There is decreased active ROM of the right knee joint secondary to pain. There is mild tenderness to palpation over the joint line. **Impression:** 1. Internal derangement of right shoulder status post-surgical repair 2. Internal derangement right knee status post-surgical repair. **Plan:** 1. WHP ordered 2. Patient medically cleared to attend the WHP

XX/XX/XX: UR. **Rationale for Denial:** The clinical information submitted for this review fails to meet the evidence based guidelines for the requested service. The mechanism of injury occurred with ten patient fell backwards onto the ground injuring his back. Current medications were not indicated. Surgical history includes right diagnostic shoulder arthroscopy, subacromial decompression, rotator cuff repair versus debridement, possible SLAP repair vers proximal biceps tenotomy with or without tendodesis, extensive debridement synovectomy on XX/XX/XX. Official diagnostic studies was not provided for review. Other therapies include surgical intervention, physical therapy and work conditioning. The patient is a male who reported an injury on XX/XX/XX. An unofficial MRI dated XX/XX/XX indicated a high grade partial interstitial tear of the supraspinatus tendon at the attachment of the foot plate of the greater tuberosity with adjacent reactive edema seen in the greater tuberosity and adjacent inflammatory changes seen in the subdeltoid bursa suggesting bursitis. A SLAP tear was noted with moderate sized osteophytes and reactive edema. The documentation indicates the patient has completed 12 visits of physical therapy. A Functional Capacity Evaluation was performed on XX/XX/XX. The patient reported right shoulder and right knee pain rated 7/10. He was able to manage 25 pounds for dynamic carry, floor to waist lift, waist to shoulder lift, and chest to overhead lift. He was assessed to be a medium PDL, while his job requires a heavy PDL. A Behavioral Evaluation on XX/XX/XX indicated the patient had a broad affect. He was off work. He had an FABQ score of 30 for work and 5 physical activity. He had a BDI-2 score of 4 and a BAI score of 5. He rated

his symptoms at 7 for pain, 1 for irritability, 1 for frustration, 7 for muscle tension, 1 for anxiety, 1 for depression, and 1 for sleep problems. He averages 7 hours of sleep per day. I spoke to XX who clarified that the patient had a job to return to but his employer was unable to accommodate any restrictions. He confirmed that the patient had 60 hours of work conditioning that was performed at a different facility under a different provider. He expressed the need for additional strength training and conditioning through a work hardening program to meet the heavy PDL of the patient occupation so that he may return to work. I discussed the BDI-2 score of 4 and BAI score of 5. Per ODG, neither re-enrollment in repetition of the same nor similar rehabilitation program is medically warranted for the same condition or injury. XX was informed of my decision and the required disclosure and he respectfully disagreed. The ODG recommend participation in a work hardening program for patient who meet guideline criteria. Furthermore, a specific return to work goal nor was job plan not seen in the records submitted for this review. Therefore, medical necessity has not been substantiated. As such, the request for work hardening program 80 hours is non-certified.

XX/XX/XX: UR. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines referenced above, this request is not certified. Per ODG, neither re-enrollment in or repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. Of note, the patient has previously participated in 60 hours of Work Conditioning. The limitations of the previous program were likewise not documented. It is unclear how the goals of the requested Work Hardening program differ from the previous work conditioning program.

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

Based on the medical records that have been reviewed, the patient has been treated with surgical intervention, physical therapy, and he has completed a work conditioning program. The patient has utilized bracing/splinting/assistive device, and taken prescription medication. Recent FCE shows that the patient is functioning at Medium PDL and his job requires Heavy PDL. The patient underwent a behavioral assessment which showed BAI as 5 and BDI-2 as 4. Based on the ODG criteria for admission to a Work Hardening Program, it is stated in the number 21 criteria, that if a patient has completed a rehabilitation program such as work conditioning, then neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury." Therefore the request for this patient to enter a work hardening program is not recommended, and this decision is upheld.

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)