C-IRO Inc.

An Independent Review Organization
1108 Lavaca, Suite 110-485
Austin, TX 78701
Phone: (512) 772-4390
Fax: (512) 387-2647
Email: resolutions.manager@ciro-site.com

Description of the service or services in dispute:

Work Conditioning Program for 20 hours for the Right Shoulder

97140 (20 units)	Physical Medicine and Rehabilitation Therapeutic Procedures
97530 (20 units)	Manual therapy techniques, each 15 minutes, requiring direct contact with physician or therapist
97112 (20 units)	Re-learning neuromuscular movement
97110 (20 units)	Therapeutic exercises and treatment for strength and movement recovery
97010 (20 units)	Therapeutic exercises and treatment for strength and movement recovery

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgeon

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

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX is a XX diagnosed with incomplete rotator cuff tear or rupture not specified as traumatic, status post right rotator cuff repair. XX was injured on XXXX when XX had been trying to remove XX had been stuck, so XX had pulled hard to free it, and immediately, XX started feeling right shoulder pain.

On XXXX, XX presented to XX for follow-up of XX right shoulder. Per note, XX was XX status post rotator cuff repair, right shoulder. XX reported that while in work conditioning, XX was gradually increasing XX weights and was making good progress. Right shoulder examination showed intact repair. It also showed supraspinatus strength 5-/5, external rotation strength 5/5, deltoid, biceps and internal rotation strength 5/5 and well-preserved range of motion.

XX was treated with medication (Norco and Neurontin), work conditioning XX, shoulder surgery XXXX (arthroscopic glenohumeral debridement, extensive; arthroscopic glenohumeral synovectomy, complete with resection of rotator interval adhesions, scar tissue, and synovium; arthroscopic subacromial decompression and bursectomy; and arthroscopic-assisted rotator cuff repair), shoulder injection and physical therapy XX.

On XXXX, right shoulder MR arthrogram showed postsurgical changes present in the area of the suprahumeral rotator cuff and greater tuberosity. The supraspinatus tendon appeared thick and heterogeneously intermediate in the signal, compatible with postsurgical change. A trace amount of contrast from the glenohumeral injection leaked into the subacromial/subdeltoid bursal space, likely through several thin linear interconnecting bands of partial tearing within the supraspinatus tendon. The amount of contrast which leaked into the subacromial/subdeltoid bursa space was less than the amount from the XXXX arthrogram study. However, no large partial or full thickness tear was appreciated.

Per Peer Review Report dated XXXX, the request for 20 additional hours of work conditioning for the shoulder was not medically necessary. The patient had undergone prior treatment (XX, per the treating provider), seemingly in excess of the XX course of work

conditioning espoused in ODG's Chronic Pain Chapter Work Conditioning topic. ODG further noted in its Chronic Pain Chapter, Work Conditioning, Work Hardening topic that one of the primary criteria for the pursuit of such a program was evidence that the patient had a specifically defined return-to-work goal or job plan, ideally agreed upon by the patient and employer. Here, however, it was not clearly stated or clearly established that the patient in fact had a job to return to as a XX. ODG further stipulated that treatment was not suggested for longer than XX without evidence of significant demonstrated gains. It did not appear that the patient had benefited appreciably with receipt of XX of work conditioning. The fact that the patient was seemingly off work and reported continuing difficulty performing activities of daily living and pain with lifting, overhead reaching and sleeping tasks taken together, suggested that the patient had effectively plateaued with receipt of extensive prior work conditioning and treatment. It did not appear likely that the patient could stand to gain from the continuation of the same. Therefore, the request for XX of work conditioning for the shoulder was not medically necessary.

Per a peer review dated XXXX, the appeal request for work conditioning XX for the right shoulder was not medically necessary. While a lack of response to utilization review addressing the specific concerns, which were valid, the current request for right shoulder was not medically necessary. Therefore, the appeal request for work conditioning XX for the right shoulder was not medically necessary.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG supports up to XX of a work conditioning program. The provided documentation indicates that XX of a work conditioning program have already been completed. In a progress note from XXXX, the clinician indicated the injured worker reported making progress with the prior work conditioning program, but there is no documentation provided to support objective improvements. Based on the provided documentation and the ODG recommendation, the request for XX of work conditioning for the shoulder is not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers
- ☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back
- ☐ Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines

Shoulder Chapter
Work conditioning, work hardening
Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. (Schonstein-Cochrane, 2003)

For more information and references, see the Low Back Chapter. The Low Back WH & WC Criteria are copied below.

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 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.

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)