

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-3585.M2**

January 29, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M2-04-0652-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in occupational medicine. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 52 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work she injured her right shoulder while lifting a bundle of packages. The patient was diagnosed with a rotator cuff tear of the right shoulder. An orthopedic evaluation dated 6/30/03 indicated that X-Rays of the right shoulder showed a type 3 acromion, moderated AC joint narrowing and infraclavicular spurring and that review of a MRI report indicated no evidence of a rotator cuff tear. The impression for this patient was right shoulder impingement syndrome, AC joint inflammation and spurring, and a right shoulder srthroscopic acromioplasty and distal clavicle resection was recommended. On 7/17/03 the patient underwent right shoulder arthroscopy and acromioplasy, and arthroscopy of the glenohumeral joint with labrale debridement. Postoperatively the patient was treated with therapy. On 9/2/03 the patient was evaluated and underwent an additional 8 weeks of physical therapy for the diagnoses of a frozen shoulder.

Requested Services

Work Hardening Program.

Decision

The Carrier's denial of authorization for the requested services is upheld.

### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 52 year-old female who sustained a work related injury to her right shoulder on \_\_\_\_. The \_\_\_ physician reviewer also noted that the diagnosis for this patient was rotator cuff tear of the right shoulder. The \_\_\_ physician reviewer further noted that on 7/17/03 the patient underwent right shoulder arthroscopy and acromioplasty and srthroscopy of the glenohumeral joint with labral debridement. The \_\_\_ physician reviewer indicated that postoperatively the patient had been treated with physical therapy and is now referred to a work hardening program. The \_\_\_ physician reviewer explained that there is little objective information available regarding the effectiveness of work hardening/work conditioning/functional restoration. The \_\_\_ physician reviewer indicated that most available literature focuses on back and neck pain as the standard, whereas this patient has shoulder pain. The \_\_\_ physician reviewer also indicated that there are several studies that have identified non-medical parameters that could influence the success or failure of a work hardening program (attorney involvement, pain tolerances, satisfaction with services). The \_\_\_ physician reviewer explained that there is little information available about end points of work hardening programs besides the obvious return to work and case closure. The \_\_\_ physician reviewer indicated that the significant goal for the patient would be returning to a specific job and that the most effective work hardening programs offer treatment built on a specific job analysis. The \_\_\_ physician reviewer also explained that there are few guidelines regarding when these services should be discontinued when the patient has not achieved the specified endpoints.

The \_\_\_ physician reviewer noted that the patient did not have a job to return to before she began a work hardening program because her position was eliminated. The \_\_\_ physician reviewer also noted that the patient had a good response to the 42 sessions of therapy she had been treated with. However, the \_\_\_ physician reviewer indicated that further treatment should be focused on developing an independent exercise program for the patient. The \_\_\_ physician reviewer explained that the documentation provided by the patient's orthopedist indicated that the patient had deficits that would be unlikely to benefit from a work hardening program. Therefore, the \_\_\_ physician consultant concluded that the requested work hardening program is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
P.O. Box 17787  
Austin, TX 78744  
Fax: 512-804-4011

**A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 29<sup>th</sup> day of January 2004.