

US Decisions Inc.

An Independent Review Organization

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Review Outcome

Description of the service or services in dispute:

Work conditioning program for an additional XX hours for the XX XX as an outpatient (received partial approval for XX hours).

XX: Conditioning and work hardening, XX XX hours

XX: Conditioning and work hardening, each additional hour following the XX XX hours

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. XX XX is a XX-year-old XX who was injured on XX. XX reported that XX was XX a XX XX of XX / XX when XX felt a XX in the XX XX, which was followed by immediate pain. XX was diagnosed with complete XX XX tear or rupture of the XX XX, not specified as traumatic (XX.XX) and pain in the XX XX (XX.XX).

A Functional Capacity Evaluation was completed by XX on XX. XX. XX reported that XX injured XX XX XX while performing XX job. XX had not returned to XX job as a XX XX at the time. XX had been moderately active since the injury and had primarily remained at home. XX continued to have XX XX pain and decreased XX XX motion. The pain was rated at 7/10 at the time. The examination revealed 4-5 XX XX extremity strength, deficits during XX XX range of motion, and XX XX range of motion including 90 degrees flexion, 50 degrees extension, 100 degrees abduction, 40 degrees abduction, 20 degrees internal rotation, and 45 degrees external rotation. XX. XX was functioning at a light physical demand characteristic level, which was defined as lifting XX pounds infrequently and XX pounds or less frequently. It did not meet XX required job demand. XX was unable to perform lifting and carrying per job demand secondary to XX XX weakness and pain. XX was not able to return to work at the time. XX would benefit from a work conditioning program as ordered by XX physician to help XX regain XX strength and functional abilities so XX might return to work.

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An MRI of the XX XX dated XX revealed no significant XX XX tears, normal postsurgical changes of the XX tendon, mild degenerative changes of the anterior and posterior XX quadrants without XX tears, moderate XX XX, moderate thickening of the axillary recess suggesting adhesive XX, and mild XX outlet related impingement with a XX distance measuring XX mm but with an intact appearance of the XX muscle and tendon. An MRI of the XX XX dated XX with a poor quality revealed a clearly torn XX tendon with retraction almost to the level of XX XX.

The treatment to date consisted of XX XX arthroscopy and arthroscopic XX XX repair on XX, XX hours of work conditioning program with progress, XX visits of XX therapy, and home exercise program with worsened symptoms.

Per the peer review and utilization review decision letter dated XX by XX, the request for work conditioning program for XX hours for the XX XX as an outpatient between XX and XX was non-certified. Rationale: "The claimant is a XX-year-old XX noted to have sustained a XX XX Injury on XX. The request for authorization noted the specific lesion as a complete XX XX tear. A work conditioning progress note dated XX indicated that multiple sessions were completed. It was noted that this individual has completed XX hours of this protocol. Additionally, a functional capacity evaluation was completed. Understanding the date of injury, noting the age of this individual, tempered by the functionality reported in the previous work conditioning protocol, the gains noted do not justify the additional XX therapy completed. Understanding the treatment to date, the amount of XX therapy as well as the work conditioning hours, there is insufficient objective data presented suggesting any substantive improvement that would require an additional XX hours of such protocol. Therefore, this is not clinically indicated."

A letter dated XX by XX documented that XX. XX had attended work conditioning program for XX hours and demonstrated good motivation throughout the treatment. XX progressed with XX lifting / carrying by XX pounds. XX demonstrated improvements in XX range of motion. XX progressed from 90 degrees of flexion to 110 degrees and 100 degrees of abduction to 110 degrees. Throughout the treatment sessions, XX demonstrated good motivation. XX appeared very motivated to get stronger in order to return to work. XX was denied participation for the remaining XX hours of work conditioning due to stating that XX did not demonstrate enough gains to warrant additional time; however, XX was making improvements in only XX week's time. XX had progressed a significant amount in range of motion and was progressing well with the lifting / carrying. With work conditioning, it was usually a XX-hour-a-day program for XX days. XX was limited by XX-XX of the typical amount so it was likely that progression would be slower as XX tended to continue to restrict treatment to allow for XX to fully participate in the program. The ODG Guidelines were for XX hours. The XX hours were supposed to show if XX was motivated to even participate in the program. XX demonstrated good motivation throughout and would significantly benefit from continued participation in the work conditioning program.

Per the peer review and utilization review decision letter dated XX by XX, the request for work conditioning program for XX hours for the XX XX as outpatient between XX and XX was denied. Rationale: "This is a XX-year-old individual noted to have sustained a XX injury on XX. The diagnosis is a XX XX tear. A previous request for a work conditioning protocol was not certified in the utilization review process. A letter of reconsideration notes that XX sessions of XX therapy had been completed, the interventions were not certified. Additionally, a request for work conditioning program was not certified and a request for a work hardening program was also not certified. It is reported that XX hours of work conditioning were completed, and this individual was noted to be lifting / carrying XX pounds. Increase in the range of motion is noted. A functional capacity evaluation was completed on XX. There is an orthopedic progress note dated XX suggesting a work hardening program be pursued."

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

The ODG supports up to *XX* visits over four weeks, equivalent to up to *XX* hours of work conditioning, as a more intensive series of *XX* therapy visits required beyond a normal course with a focus on work required endurance. Ongoing treatment is supported if there is documentation of significant gains after *XX* to *XX* weeks. The documentation provided indicates that the injured worker has a diagnosis of a *XX XX* complete *XX XX* tear. The injured worker has completed *XX* sessions of *XX* therapy and *XX* hours of a work conditioning program. A letter from the *XX XX* indicates that after *XX* hours of work conditioning over a one-week period the injured worker improved 10° range of motion in abduction, 20° of range of motion in flexion, and was able to lift/carry an additional *XX* pounds. There is a request for additional *XX* hours of work conditioning as the injured worker is motivated to return to the previous job which requires a medium capacity level and is currently functioning at a light to medium capacity after *XX* hours of work conditioning. Given that the injured worker has improved with respect to range of motion and strength after *XX XX/XX* hours of work conditioning, the ODG would support ongoing work conditioning for the injured worker as there have been functional gains. Without continued work conditioning the injured worker will not be able to return to a prior level of function and the previous work level and would require permanent restrictions. As such, certification for the additional *XX* hours of work conditioning is considered 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
- 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
XX

- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- Texas TACADA Guidelines

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- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Medical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.