



DATE OF REVIEW: 11/05/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The case involves the medical necessity of continued work conditioning.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., board certified in Chiropractic Orthopedics, with special training for expertise in Pain Management and Rehabilitation.

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

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

INFORMATION PROVIDED FOR REVIEW:

- TDI Confirmation of Receipt of a Request for a Review by an IRO, submitted 10-26-07.
- report dated 9-19-07, Requestor, DC, Treating Physician, DC. Diagnosis: Ankle sprain/strain. ICD-9: 825.22, 845.00. CPT: 97545, 97546. Request: Work Conditioning 5x2. Recommendation: Adverse. Review: Initial preauth UR. History of Condition: female sustained a navicular fx right foot on xx/xx/xx. Extensive physical therapy including 10 sessions of work conditioning. FCE dated 9-14-07 indicated ability in NIOSH tests and inability to complete dynamic testing due to foot pain, not conditioning. Claimant is xx months post injury, has had extensive physical therapy and currently works modified duties to include opportunity to walk, bend, stretch, and bear weight on affected foot/ankle. Recommendation is for non-authorization.
- report dated 10-4-07, Appeal Pre-auth, Adverse Determination. Dr. cites ODG and ACOEM.
- letter to dated 10-30-07.

- IRO summary dated 10-30-07. Reported mechanism of injury: “Walking up and down a ladder stocking infant Pampers, began to feel swelling and pain in right foot (May have stepped off of the ladder wrong).” List of referrals/consultations, diagnostic imaging, physical medicine treatments, medication history and DME.
- Employer’s first report, xx/xx/xx for injury xx/xx/xx. Body part: ankle. Nature of injury: fracture/break.
- letter of dispute dated xx/xx/xx for injury xx/xx/xx. I’m assuming that the patient wasn’t sure of the injury date.
- Injured (questionnaire): Patient was stepping off a ladder while working with diapers xx/xx/xx to xx/xx/xx. She went to her primary care doctor on xx/xx/xx and reported the injury to her employer on xx/xx/xx.
- Work/School Release note from, DPM, xx/xx/xx.
- Center forms, xx/xx/xx. Patient c/o swelling and painful to stand on the foot. A nurse practitioner, noted that the x-rays revealed a “possible” fracture and diagnosed “fracture of the right foot navicular.” The nurse also noted that the right foot was affected by polio and that it was deformed and significantly smaller than the left foot.
- TWCC Work Status Report, xx/xx/xx, , MD, return to work with restrictions on xx/xx/xx, expected to last through xx/xx/xx (? , illegible).
- Physician Report, MD. DX: 825.22 Fracture navicular bone, closed.
- final report xx/xx/xx. Detailed history of injury. No trauma. X-ray report as “possible” fracture of the tarsal navicular.
- TWCC Work Status report dated xx/xx/xx by, MD.
- Dictation by Dr., progress report, xx/xx/xx The patient does not recall any specific injury event, but noticed pain onset while at home in the evening. She has history of polio affecting the right leg. X-rays do not reveal any sign of fracture.
- TWCC Work Status Report by, DC with Injury Center of , not dated, but took patient off work from xx/xx/xx to 5-24-07. DX: Right heel fracture and 729.2 neuritis. Prescribed physical medicine treatment 3 times per week for 3 weeks.
- Initial Consultation by Dr. xx/xx/xx. History of injury is quite different from the previous accounts. This account states that she awkwardly contacted the floor with her right foot and felt a sharp pain at that time, left work early to go to her doctor. She could not return to work due to pain and swelling. The previous doctor prescribed physical therapy, but the therapists never contacted her for an appointment. Dr. initiated physical therapy and sent her for specialty evaluation and medical co-management within his facility.
- Daily Progress Notes by Dr. with, from 5-18-07 to 5-25-07.
- MRI right ankle from Memorial MRI & Diagnostic by, MD dated 5-30-07. Reveals mild tenosynovitis, mild tendonopathy, and mild plantar fasciitis, and talofibular ligament strain.
- MRI right foot from Memorial MRI & Diagnostic by, MD dated 5-31-07. Impression: No abnormalities.
- Daily Progress notes, Center, from 6-1-07 through 6-8-07, for passive and active therapy.
- ROM test report from, two reports, 6-7-07 and 6-22-07.

- TWCC Work Status report by Dr., patient can RTW with restrictions from 6-24-07 to 7-24-07. Referral to “ortho.”
- DPM, handwritten report, xx/xx/xx.
- Initial Report by, MD, PhD on Center. Dx: Right ankle fracture, right ankle synovitis. Rx: meds.
- EMG/NCV studies 8-6-07 by Summit Diagnostics. MD. Impression: unremarkable.
- Pre-authorization request by, DC on 8-17-07 for 20 sessions of work conditioning. Treatment plan: “Work conditioning individualized protocol concentrating on improving muscular and connective tissue flexibility, muscular strength and endurance, body mechanics, cardiovascular conditioning, and functional performance by means of work simulation.”
- Pre-authorization request by, DC on 9-14-07 for 10 additional sessions of work conditioning. Treatment plan: “Work conditioning individualized protocol concentrating on improving muscular and connective tissue flexibility, muscular strength and endurance, body mechanics, cardiovascular conditioning, and functional performance by means of work simulation.”
- FCE report dated 9-14-07. Report by, BS in kinesiology, showing abilities and deficits, and including PDL categories.
- Letter by, DC as rebuttal to denial for pre-authorization. Patient has been on modified duty status for 100 days. Dr. states that she is unable to return to full duty, and that in all medical probability, the patient would be able to return to regular duties with 10 additional sessions of work conditioning.
- Patient Re-Evaluation, 9-26-07, by, DC.
- MRI right foot, xx/xx/xx, apparently an over-read by another radiologist, MD. Findings: “Bone bruise / bone contusion with associated non-displaced microtrabecular fracture in the first cuneiform bone. Bone bruise / bone contusion is also seen in the navicular bone, talus, and calcaneus bones.”

INJURED EMPLOYEE CLINICAL HISTORY (Summary): The patient reported her injury of xx/xx/xx or xx/xx/xx as walking up and down a ladder to stock diapers, perhaps stepping down from the last step, and began to feel pain in right foot. She noticed swelling. One record says that she left work and reported to her family doctor. Another record says that she went to her family doctor on xx/xx/xx and reported the injury to her employer on xx/xx/xx. She actually went to a podiatrist on xx/xx/xx and to on xx/xx/xx. A nurse practitioner reported a possible fracture of the tarsal navicular and listed her diagnosis as a fracture. Other reports within followed suit with the fracture diagnosis, although a doctor on xx/xx/xx reported that the x-ray did not show a fracture. MRI of the ankle and foot on 5-30-07 and 5-31-07 respectively did not reveal a fracture according to the first radiologist. A different radiologist apparently over-read the scan of the foot and described a “bone bruise/contusion” and “microtrabecular fracture” of a different bone (the first cuneiform), along with contusions of the navicular, talus, and calcaneus. The file also indicates chronic foot deformity from polio affecting the right lower extremity. The patient has had at least six range of motion tests, six muscle tests, PT, ten work conditioning sessions, trigger point injections, at least five different prescription medications, and at least four different durable medical equipment prescriptions for home

use including a TENS unit, an electrical stimulator, an electrical heat unit, and a paraffin bath unit. It also appears that she has seen at least nine different medical specialists, most recently under the direction of Dr., a chiropractor with. Current status of the patient is that she is not capable of regular duties in her job description with Medium PDL, but qualifies for Light/Medium. Treatment plan is for ten additional sessions of work conditioning with anticipation of MMI and full release upon completion.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONSLUSIONS USED TO SUPPORT DECISION:

Generally in the case of work-related injuries such as a sprained foot, the treating doctor provides pain-relieving modalities in the acute phase of the injury, up to about 3 to 4 weeks post injury date, then transitions the patient as quickly as possible into active rehab, the purpose of which is to 1) prevent further de-conditioning that would preclude a timely return-to-work, 2) strengthen and restore function to injured soft tissues and the body as a whole, and 3) instill confidence to the injured worker that he/she can perform the anticipated job duties. A typical rehab program for a strain/sprain of the foot without complications would begin within about 6 weeks from the onset of the injury, and conclude within 12 weeks from the onset of the injury. In the context of the program, the patient would be instructed in home-based exercise and perhaps modified ADL so as to increase functional abilities. In this case, however, the patient's injury occurred about six months ago. She has had multiple examining doctors and extensive treatment for the past six months for a most likely diagnosis of simple strain of a dystrophic post-polio foot. There is no definitive and convincing evidence of a fractured foot, but rather an apparent perpetuation of the diagnosis originated by a nurse practitioner. The MRI done a month later shows a "microtrabecular" fracture of a different bone than was originally diagnosed. In summary, the discrepancies in this file obscure an otherwise finely documented case for additional work conditioning. I do not find an indication for additional formal work conditioning at this time. A home-based continuation of the first 10-visit program would have brought her to MMI and function. The patient is either qualified for her job duties at this time or she will never be qualified in my opinion.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- X_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 national accepted medical literature (provide a description).
- _____ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)