

## NOTICE OF INDEPENDENT REVIEW DECISION

April 30, 2003

RE: MDR Tracking #: M2-03-0355-01  
IRO Certificate #: IRO4326

The \_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This patient sustained a work-related injury on \_\_\_ when he tripped over an underground lid handle. The patient fell to the ground and injured his right foot and right groin. The patient's injuries have been characterized as sprain/strain type injuries. X-ray studies, an MRI, and a CAT scan were performed and were reported as normal. The patient has undergone an extensive course of care including passive modalities and active modalities including rehabilitative care. He has also undergone several functional capacity examinations (FCE) or independent evaluation. The patient continues to experience significantly decreased ranges of motion and significant pain levels.

### Requested Service(s)

Work-conditioning program

### Decision

It is determined that the work-conditioning program is not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The patient sustained a sprain/strain soft-tissue type injury to the right foot. The medical record documentation does not contain any ancillary testing or objective information that would support that any complicating factors exist that is prolonging recovery. There are no apparent issues complicating his recovery and the normal expected natural history for this condition has expired.

The patient has undergone an extensive course of active care as well as rehabilitation and passive modalities. It is unclear that the patient has progressed through the course of care offered to date. Over the course of two FCE's given in July 2002 and September 2002, the patient's symptoms, objective findings and functional abilities worsened. It is unlikely that additional active care or rehabilitation would likely bring about any additional therapeutic gain than what has already been established.

The patient has been diagnosed with some depression. There is no indication that a psychological interview or assessment has taken place to properly diagnose the patient's psychosocial issues and ascertain whether or not they are influencing the patient's current symptomatology. It is unknown whether or not these depressive symptoms would threaten the success of additional rehabilitative care including work conditioning.

The American Physical Therapy Association indicates that work conditioning and /or work hardening should not be initiated after a year following the date of injury unless a comprehensive multi-disciplinary assessment and /or examination precede the program. The American Physical Therapy Association additionally indicates through studies that the success from the initiation of work conditioning more than one year following the onset of symptoms is unclear and poorly defined.

Therefore, due to the fact that this patient's symptomatology has increased from at least July to September of 2002 during a rehabilitative care and due to the presence of psychosocial issues and due to the time that has passed since the onset of his symptoms, the work-conditioning program is not medically necessary.

This decision by the IRO 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** (10) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **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,

In accordance with Commission Rule 102.4 (h), 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 30<sup>th</sup> day of April 2003.