

March 5, 2003

MDR #: M2-03-0542-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:

This 40-year-old male claimant lacerated the volar aspect of his left fourth digit of the upper quarter while on his job on ____. Surgical applications were performed on 08/03/02, which included a Z-plasty of the left fourth digit and a flexor tendon sheath tenolysis of the left fourth digit.

A Functional Capacity Evaluation was performed on 06/18/02 that indicated that the patient could safely lift weight that will qualify at a light/medium physical demands level. No psychosocial deficits were documented, and no psychosocial baseline of function was noted at that time. An FCE on 10/25/02 showed no psychosocial deficits of function and no psychosocial baseline of function was noted.

Disputed Services:

Work hardening program 5 X weekly for 6 weeks.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that a work hardening program is not medically necessary in this case.

Rationale:

The medical records provided show no evidence for the application of work hardening therapies vs. work conditioning therapies. The patient has no recorded psychosocial deficits in either of the functional capacity evaluations conducted. The patient does not show any deficits that would warrant the introduction of behavioral focus therapeutics. In addition, medical records show that the patient's employer attempted to comply with work restrictions for the patient as early as 04/19/02.

The above-mentioned information has been taken from the following clinical guidelines of practice:

- *Clinical Practice Guideline for Chronic Non-Malignant Pain Syndrome Patients II: An Evidence-Based Approach.* Journal of Back Musculoskeletal Rehabilitation, 1999, Jan 1; 13:47-58.
- *Unremitting Low Back Pain, North American Spine Society Phase III Clinical Guidelines for Multi-Disciplinary Spine Care Specialists,* North American Spine Society. 2000, 96 p.
- *Overview of Implementation of Outcome-Assessment Case Management in the Clinical Practice.* Washington State Chiropractic Association, 2001, 54 p.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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.

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 March 5, 2003.