

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** February 5, 2004

**RE: MDR Tracking #:** M2-04-0628-01  
**IRO Certificate #:** 5242

\_\_\_ 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 Chiropractic physician reviewer that has ADL certification. The Chiropractic physician reviewer 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**

According to the supplied documentation, it appears that the claimant was injured at work on \_\_\_ when another employee backed a vehicle into him, causing him to be pinned between a bay door and the vehicle. The claimant was seen at \_\_\_ where he was diagnosed with a contusion to his chest wall and to his abdomen. The claimant underwent some physical therapy and was seen by an orthopedic specialist. The claimant later changed treating doctors to \_\_\_. The claimant underwent chiropractic therapy. The claimant had diagnostic testing performed including a FCE. The claimant was seen a designated doctor on 10/21/2003. The documentation ends here.

### **Requested Service(s)**

Please review and address the medical necessity of the services that include a work hardening program for 6 weeks.

### **Decision**

I agree with the insurance company that the work hardening program is not considered reasonable or medically necessary.

## **Rationale/Basis for Decision**

The supplied documentation reports that the claimant sustained a chest and abdominal contusion as a result of his \_\_\_ compensable injury. The documentation supports an adequate amount of therapy has been rendered in the claimant's case. The FCE performed on 09/30/2003 places the claimant on a light physical duty. There apparently is some contradiction in whether the claimant's job is a medium duty or a heavy duty. According to the JOB GENIE website (<http://www.stepfour.com/jobs/index.htm>), the claimant's job requires a medium duty job capacity. There is no objective documentation provided that supports ongoing therapy. A designated doctor exam was performed on 10/21/2003 and states that the claimant has a total whole person impairment of 0%. Since there was no impairment determined by the designated doctor and no objective diagnostic findings that support anything beyond a chest contusion

The claimant should be able to return to work at a full capacity. There is not any documented rationale for 6 additional weeks of work hardening that would prevent the claimant from returning to work. Since he is physically able to work and does not have any impairment, it would be reasonable to return him to work and to continue to monitor his condition. The claimant has been diagnosed with a contusion. Without any complications (none were found) the amount of therapy performed in this case has far exceeded normal treatment guidelines.