

MDR Tracking Number: M2-04-1052-01
IRO Certificate # 5259

April 13, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in orthopedic surgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

___ is known to have a **right** foot problem, i.e. a flexor hallucis longus rupture. ___ new problem and the work related event was a **left** foot problem. Without any antecedent trauma while simply walking at work, he had the immediate onset of pain in the left mid foot with the cessation of function and his ability to flex the left great toe. ___ and ___ document this. Both agree that a flexor hallucis longus rupture has occurred very similar to the contralateral foot but declared a work injury and declared the need for surgery. Under a pre-authorization process, this was denied on two different occasions by two different physicians. There is documented comment that both attempted telephonic conversation with the treating physicians but to no avail.

REQUESTED SERVICE (S)

Repair, Tendon Foot, Flexor, each, without free graft

DECISION

Approve.

RATIONALE/BASIS FOR DECISION

This patient has a medical necessity for an exploration of the foot and most likely a repair of the flexor hallucis longus. The MRI of the left foot was reviewed on 2/10/04. It was unremarkable but there is good clinical evidence documented by two orthopedic surgeons over a period of a month that this in fact is clinically apparent. There is a possibility the MRI has not imaged the area where the flexor tendon is ruptured. There is comment that this patient has an elongated mid foot incision on the right side. Again, this is an exploration type surgery, and he needs similar surgery on the left. An FHL tendon needs to be repaired; functioning without it is somewhat disabling, so it is medically necessary. The opinions rendered in this case are the opinions of the evaluator. This evaluation has been conducted on the basis of the medical documentation provided with the assumption that the material is true, complete, and correct. If more information becomes available at a later date, then additional services, reports, or reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment from the documentation provided.

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** (ten) calendar days of your receipt of this decision (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

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 14th day of April 2004.