

MDR Tracking Number: M2-04-1141-01  
IRO Certificate # 5259

April 27, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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

Available information suggests that this patient reports a right knee injury occurring as a result of work related activity on \_\_\_\_. He was initially treated with physical therapy, which did not resolve pain and instability. He had a MRI performed 03/09/01 suggesting a full thickness tear of the anterior cruciate ligament. He was referred for orthopedic assessment by \_\_\_ in \_\_\_ on 09/24/01 who recommended ACL reconstruction with hamstring graft. The patient moved back to his home in \_\_\_ and begins seeing a chiropractor, \_\_\_ in October of 2003. No initial chiropractic examination is provided for review. It is unclear what sort of treatment or medical evaluation this patient had in the interim (2 years) between September of 2001 to October of 2003. The patient is referred for second orthopedic evaluation with \_\_\_ on 10/22/03. Again, arthroscopic reconstruction is recommended and eventually performed 11/24/03. The patient is referred to another chiropractor, \_\_\_, for post-operative physical therapy on or about 12/16/03. Again, no chiropractic examination or findings are provided for review. There are a number of chiropractic SOAP notes from the \_\_\_ in \_\_\_ suggesting that the patient is improved with passive modalities and therapeutic exercise post-operatively. A 01/14/04 progress note is submitted from \_\_\_ indicating that some weakness and apprehension does persist and the patient is referred for work hardening.

This order is again confirmed on 02/25/04 and referral for work hardening is apparently made with \_\_\_\_\_. The patient apparently continues with \_\_\_\_\_ for chiropractic modalities and rehab again suggesting that work hardening needs to be performed. No mention of home exercise or self-care instruction appears to be given. No functional capacity evaluation is submitted for review and no psychosocial or behavioral evaluation appears to be made.

REQUESTED SERVICE (S)

Work Conditioning Program x 20 Sessions.

DECISION

Medical necessity for Work Conditioning program of this nature is **not** supported by available documentation. Therefore, services requested are denied.

RATIONALE/BASIS FOR DECISION

Available documentation does not meet TWCC or Standardized Treatment Guidelines for individuals qualifying for Work Conditioning/Work Hardening programs. This file contains no objective measurements suggesting specific functional deficits related to compensable injury. In addition, there is no indication that this patient lacks appropriate motivation to complete an active rehabilitation program or achieve some level of individualized home based exercise/self-care program. All provider documentation appears to request Work Hardening rather than Work Conditioning and there appears to be inadequate documentation to support either of these programs at this time.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

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 28<sup>th</sup> day of April 2004.