

## NOTICE OF INDEPENDENT REVIEW DECISION

September 16, 2002

RE: MDR Tracking #: M2-02-0943-01  
IRO Certificate #: 4326

\_\_\_ 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 57 year old male sustained a work-related injury on \_\_\_\_. The origin of the injury is not clearly identified in the information submitted for review. The plan of care consisted of conservative treatment and surgical intervention. On 06/27/02 the patient underwent bilateral lumbar decompression at L3-4, L4-5, and L5-S1. Postoperative care included work hardening. The treating chiropractor has recommended work hardening for an additional 2 weeks at 5 times per week.

### Requested Service(s)

Work hardening 5 times per week for 2 weeks

### Decision

It has been determined that additional work hardening 5 times per week for 2 weeks is medically necessary.

### Rationale/Basis for Decision

The documentation submitted for review substantiates that additional work hardening is medically necessary. The attending physician's documentation presented relevant clinical findings and identified functional, physical, behavioral and vocational deficits that would benefit from additional work hardening to maximize the patient's ability to return to work. The medical necessity is also supported by the initial and current functional capacity evaluation. Also, the treatment guidelines and standard of care as set forth by the North American Spine Society Clinical Guidelines for Multidisciplinary Spine Care Involving Herniated Disc and Unremitting Low Back Pain, Guidelines for Low Back Pain in Primary Care Setting by the Department of Veterans Affairs (May 99), and the Guidelines for Psychiatric and Psychological Evaluation of Injured or Chronically Disabled Workers by Washington State Department of Labor and Industries (June 99), all support the use of multidisciplinary work hardening programs. Therefore, the work hardening 5 times per week for 2 weeks is medically necessary.

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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,