

October 10, 2003

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

MDR Tracking #: M2-04-0083-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ is a female employee who was lifting cases of food that weighed 25 lbs. and felt low back pain. She was seen at \_\_\_ in \_\_\_ where she had an MRI that identified L5/S1 left posterior lateral spondylosis and herniation resulting in stenosis of the left L5 neural foramina and spondylosis and L4/5 bulging resulting in a mild central stenosis. Her cervical MRI was reported as having diffusely diminished disc spaces, but no neural foraminal narrowing or compression. She was taken off work and given physical therapy. Gradually, her pain subsided in February 2003. On 1/13/03 she was evaluated for FCE at the \_\_\_. The patient was said to be cooperative throughout the evaluation and her behavior profile reported that there was nonexistent inappropriate illness behaviors for symptomatic medication. She scored 0 on Waddell's sign for non-organic symptomatology. She was stated as to be motivated and her examinations were considered valid. She could only perform at the sedentary light physical demand levels. Her job specifically required medium physical demand levels. Her physician recommended a work hardening program that was denied by the insurance carrier. Work conditioning was approved for four weeks. On the basis of \_\_\_ and \_\_\_ recommendations, work hardening was denied.

#### REQUESTED SERVICE

A work hardening program is requested for this patient.

## DECISION

The reviewer disagrees with the prior adverse determination.

### BASIS FOR THE DECISION

Work hardening has been a recognized method of returning employees to work at the level of physical demand required for their job. \_\_\_ is did not meet the median PDL's required for her job. Work hardening is a reasonable method of returning the injured worker to her former level of function.

The reasons the carrier physician reviewers denied services were because the patient was morbidly obese, because there was a lack of evidence of significant pathology, and because of symptom magnification.

The reviewer finds that the patient is deserving of the requested medical treatment, regardless of her obesity. There is significant pathology in the lumbar MRI findings of L5/S1 left posterior lateral spondylosis resulting in stenosis of the left neural foramen. And last, FCE documentation provided to the \_\_\_ reviewer did not indicate symptom magnification. Therefore, the reviewer finds that denial of work hardening was inappropriate.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

### YOUR RIGHT TO REQUEST A HEARING

Either party to 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 (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

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

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 10<sup>th</sup> day of October 2003.**