

February 9, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-04-0585-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 49 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he was the driver of a forklift when he injured his back. A discharge summary and treatment request from \_\_\_ dated 8/12/03 indicated that the diagnoses for this patient included cervicobrachial syndrome (diffuse), thoracic facet syndrome/lumbar facet syndrome, acute post traumatic low back syndrome, spasm of muscle, and other specified adjustment reaction, secondary to chronic pain. It also reported that the patient completed a chronic pain program and was recommended for a work hardening program. A progress note dated 10/30/03 indicated that the patient had completed 20 sessions of work hardening and was going to be referred for additional work hardening. It also indicated that an MRI of the lumbar spine showed moderated degenerate change to the L4-L5 level with 2-3mm bulge protrusion without compression, and minimal facet arthropathy at the L4-L5 level. It further indicated that previous testing showed cervical facet asymmetry at C1-C2 and degenerative changes to the cervical and lumbar spine.

### Requested Services

Work Hardening Program times 4 additional weeks.

### Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 49 year-old male who sustained a work related injury to his back on \_\_\_. The \_\_\_ physician reviewer also noted that the patient began a work hardening program on 8/14/03 and attended 17 days through 10/23/03. The \_\_\_ physician reviewer indicated that the patient made minimal progress in the program. The \_\_\_ physician reviewer also indicated that the last two weeks of work hardening, the patient remained at the same level (no major changes from start of program). The \_\_\_ physician reviewer noted that the patient continued to complain of pain rating 7/10 with walking, was unable to perform sustained upper or lower body routines, and was inconsistent with work simulation task performance. The \_\_\_ physician reviewer explained that the patient has demonstrated poor progress with the work hardening program and continued to complain of significant pain during activities. Therefore, the \_\_\_ physician consultant concluded that the requested Work Hardening Program times 4 additional weeks is not medically necessary to treat this patient's condition at this time.

This decision 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 (ten)** 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 a hearing should be sent to:

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

**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,

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 9<sup>th</sup> day of February 2004.