

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0727-01  
IRO Certificate No.: 5259

February 10, 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 injury to his back occurring while at work on \_\_\_ when he fell from a chair onto a metal table. The patient began seeing a chiropractor, \_\_\_ on 4/21/03. The patient was diagnosed with lumbar sprain/strain and began treatment with chiropractic manipulation and passive modalities. The patient is also referred to a \_\_\_\_, and is prescribed multiple medications. An MRI is obtained 5/5/03 suggesting L5/S1 degenerative disc disease without neurological compromise. The patient is referred for neurological evaluation on 6/3/03 with \_\_\_\_, who requests lumbar myelogram with post myelogram CT and bilateral EMG. EMG performed 6/16/03 was found essentially normal, and myelogram and post myelogram CT were largely unremarkable. Follow-up with \_\_\_ suggests that patient undergo pain management program and ESI's.

FCE is performed 7/22/03 suggesting remaining functional deficits with patient meeting only light work demand level. A psychological evaluation is also performed 8/26/03 suggesting some issues of anxiety and depression related to inability to return to work.

The patient appears to change treating doctors and begins seeing another chiropractor, \_\_\_ on 9/29/03 and appears to undergo another month of therapy before having another FCE performed on 10/30/03. This evaluation appears to suggest that conservative care has failed to return patient to functional work capacity and work hardening program is again recommended.

#### REQUESTED SERVICE (S)

Determine medical necessity for proposed work hardening program 5x per week for 6 weeks.

#### DECISION

Approval of work hardening program for 4 weeks.

#### RATIONALE/BASIS FOR DECISION

Available documentation does support patient selection criteria for a work hardening program. Work hardening program does appear medically necessary. However, due to the patient's apparent failure with previous therapeutic programs, it would appear that approval for a 4-week program would be best advocated.

1. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1): 10-20.
2. Bigos S., et al., AHCP, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
3. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" *Journal of Family Practice*, Dec. 2002.
4. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4): 182-189.
5. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers.
6. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
7. Work hardening guidelines, American Occupational Therapy Association, *Am J Occup Ther.* 1986; 40(12): 841-843.

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 claimant. These opinions rendered do not constitute a per se 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 12<sup>th</sup> day of February 2004.