

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-1372-01
IRO Certificate Number: 5259

July 21, 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 Texas Medical Foundation, 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 ___.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports a work related back injury on ____. MRI performed 03/06/03 reveals L4/5 disc herniation. Neurosurgical consultation with _____ recommends lumbar laminectomy. The patient then appears to go several months without care then seeks treatment from a chiropractor, ____. After several weeks of physical therapy with ____, the patient finally underwent surgery with ___ on 09/01/03. Several months of post-operative physical therapy and rehabilitation was then continued with ___ with little functional improvement documented. The patient

also underwent occupational therapy with ___ through 02/23/04 with FCE performed and work hardening program recommended. No psychosocial or behavioral assessment appears to be performed. On 04/020/04, the patient is referred for pain management with a ____, suggesting little improvement with chiropractic treatment, physical and occupational therapy. The patient is found with post laminectomy syndrome with persistent left radiculopathy. A series of caudal ESIs and adhesion lysis is recommended.

REQUESTED SERVICE(S)

Determine medical necessity for requested Work Hardening Program x4-6 weeks.

DECISION

Denied. Medical necessity for Work Hardening program of this nature is not supported by available documentation.

RATIONALE/BASIS FOR DECISION

Available documentation does not meet TWCC or Standardized Treatment Guidelines for individuals qualifying for Work Hardening programs. This file contains no behavioral or psychosocial assessments suggesting need for group counseling component of work hardening. Due to lack of significant improvement with active rehabilitation to date, it is unlikely that this patient will be able to return to previous level or type of employment. In addition, it appears that progress barriers have been identified due to post laminectomy syndrome and post surgical adhesions. At this late stage, it is unlikely that this patient will benefit from work hardening or work conditioning activities. Chronic pain management (utilizing ESIs and adhesion lysis) and vocational rehabilitation counseling appears to be most indicated at this stage.

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 22nd day of July, 2004.