

## **NOTICE OF INDEPENDENT REVIEW DETERMINATION**

MDR Tracking Number: M2-04-1564-01  
IRO Certificate Number: 5259

August 3, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. 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

The records provided indicate that this is a 40-year-old Latin-American female who developed pain on \_\_\_ when she was moving a washer and dryer. Apparently, this was a work-related event. She has been seen by a chiropractic physician and had evaluation with MRI in April of 2001 showing disk protrusion at L4-L5, annular tear at L5-S1, and degenerative disk disease. She weighs approximately 338 pounds, had recent MRI in this past year of the lumbar spine revealing degenerative changes at L5-S1. Her treatment has included epidural

steroid injections x 2 in 2001, and annuloplasty at L5-S1, IDET procedures, and physical therapy. The records indicate she continues to complain of back pain and \_\_\_\_ who is requesting physician, has diagnosis of back pain, lumbar pain, discogenic spinal stenosis, and multi-level displacements with neural compression. Therapy notes document essentially normal strength with no focal deficits and normal reflexes with some pain on straight leg raising.

REQUESTED SERVICE(S)

Motorized scooter/power lift chair.

DECISION

Denied. Concur with the carrier's determination that these are not medically reasonable or necessary as a result of work-related injury of \_\_\_\_ of moving driers.

RATIONALE/BASIS FOR DECISION

Standard principles of care for someone with lumbar degenerative disk disease and spinal stenosis would include all the treatments this individual has received including MRI diagnostics, myelogram, EMG, injection therapy with epidural steroid injections, and facet injections, and facet therapy. In a morbidly obese individual such as this, gait abnormality is generally not a dysfunction as a result of the spinal stenosis other than what is referred to a spinal neurogenic claudication, meaning the patient can only walk certain distances and beyond which becomes weak. That has not been documented as a problem in this individual and in fact the records indicate she has pain when she walks long distances but not that she is incapable of walking long distances. The device requested is an appropriate device for someone with gait dysfunction as a result of degenerative arthritis of the knees or hips but is generally not accepted indication to get such a device for degenerative disk disease or spinal stenosis. There is no specific literature, but these are the accepted standards of care and treatment for the area.

## 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 4th day of August, 2004.