

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0423-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance Company
Name of Provider: (ER, Hospital, or Other Facility)	Forward Health Solutions
Name of Physician: (Treating or Requesting)	Dr. H, DC

December 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Medical Director

cc: _____

Forward Health Solutions

Dr. H, DC

Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Correspondence and treatment records from the provider
2. Operative report and correspondence from the surgeon
3. Psychological evaluations and treatment notes
4. "Work Hardening Program" progress notes
5. Correspondence from Forward Health Solutions
6. Carrier review decision
7. Correspondence and treatment notes from Odessa Injury Rehabilitation
8. Functional capacity and physical performance evaluations
9. Diagnostic Imaging reports

Patient underwent physical medicine treatments and cervical spine surgery after sustaining an on-the-job injury on ____.

REQUESTED SERVICE(S)

Prospective medical necessity of the proposed work hardening program - 5X per week for 2 weeks.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

No treatment records were available for review during the time period from the 09/22/04 physical performance examination and the 11/02/04 physical performance examination. However, based on those two reports, the patient was being treated in some manner at Odessa Injury Rehabilitation during that time frame. Based on the 11/02/04 and 11/04/04 "Work Hardening Program" progress notes by _____, LPC, the patient was in a work

hardening program on those dates. Since no treatment notes were supplied for this time frame, it is unknown what kinds of therapies and/or treatments were attempted, what was beneficial and what was not, and is the proposed work hardening program different or more of the same? Without medical treatment records that answer those questions, there is less than sufficient documentation to support the medical necessity of the proposed treatment.

The proposed work hardening is also not supported by current medical literature which states, "...there is no strong evidence for the effectiveness of supervised training as compared to home exercises. There is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care."¹ Moreover, the previously attempted psychological sessions and physical medicine treatments had within them the self-help strategies, coping mechanisms, exercises and modalities that are inherent in and central to the proposed work hardening program. Therefore, since the patient is not likely to benefit in any meaningful way from repeating unsuccessful treatments, the work hardening program is medically unnecessary.

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).

¹ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

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 21st day of December, 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: