

February 10, 2005

Ms. Linda Kinney
Syzygy Associates
C/o Magnolia Workskills
1100 Bridgewood Drive, Suite 108
Ft. Worth, TX 76112

VIA FACSIMILE
Dolgencorp
C/o Flahive Ogden & Latson
Attn: Katie Foster

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0658-01
TWCC #:
Injured Employee:
Requestor: Syzygy Associates
Respondent: Dolgencorp c/o Flahive Ogden & Latson
MAXIMUS Case #: TW05-0011

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS 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 occupational medicine, preventative medicine and public health and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 54 year-old female who sustained a work related injury on _____. She reported that she felt a pop in her back and noted immediate low back pain while moving large bottles at work. The patient was initially seen in the emergency room. The report from a MRI of the patient's lumbar spine that was performed on 10/15/03 indicated that the impression was

segmentation anomaly with partial sacralization of L5, minimal disc spondylosis and an outer annular fissure posteriorly to the left at L2-3, mild disc spondylosis with a 2mm central protrusion lateralizing slight to the left at L3-4, and moderate/severe bilateral facet arthrosis at L4-5. On 10/30/03, the member saw an orthopedic surgeon. The record from this visit indicated that the assessment was facet arthrosis along with back pain and mild radicular symptoms. On 12/5/03, the patient had a pain management consultation. The record from this visit indicated that the assessment was lumbar facet arthropathy, lumbar spondylosis, lumbar disc displacement, cervical facet arthropathy and lumbar discogenic pain. The report from a MRI of the patient's pelvis performed on 1/5/04 indicated that there was no abnormal osseous signal in the region of the sacrum or coccyx. On 2/20/04, the patient saw an orthopedic surgeon. The record from this visit indicated that her complaints were low back pain, pain radiating to her hip, and coccygeal pain. It noted that the results of a bone scan were normal. It indicated that the impression was coccydynia along with right greater trochanteric bursitis. The patient has been treated with epidural steroid injections, sacroiliac joint injections, physical therapy, chiropractic treatment, a pillow, pain medications and anti-inflammatory medications. A work hardening program has been recommended for her.

Requested Services

Work hardening program 5 times a week for 6 weeks.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. No Documents Submitted

Documents Submitted by Respondent:

1. Emergency room records dated ____
2. Report from a MRI scan of the patient's lumbar spine, performed on 10/15/03
3. Report from a MRI scan of the patient's pelvis performed on 1/5/04
4. Report from a bone scan performed on 2/2/04
5. Orthopedic surgery progress reports dated 10/9/03, ____, 10/30/03, 12/18/03, 1/15/04, 2/20/04, 8/26/04
6. Report from a pain management consultant on 12/5/03
7. Reports from epidural steroid injections on 12/5/03
8. Physical therapy records from 11/17/03 to 12/1/03
9. Report from a pain management consultant on 3/8/04
10. Letter from the member's chiropractor dated 6/28/04 and chiropractic treatment records dated 6/28/04 to 10/1/04
11. Designated doctor evaluation report dated 5/22/04
12. Initial consultation report dated 7/13/04, procedure note dated 7/28/04 and letters regarding visits on 8/3/04
13. Required medical examination report dated 4/13/04

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury to her back on _____. The MAXIMUS physician reviewer indicated that the patient was initially treated with medication, physical therapy, chiropractic management (with active physical therapy), epidural steroid injections, and SIJ injection with little improvement documented. The MAXIMUS physician reviewer noted that after eight months of initial treatment the patient changed treating doctors. The MAXIMUS physician reviewer indicated that the patient was then treated with exercise regimens twice per week for 1.5 hours each session and that her treating doctor felt that work conditioning or hardening was indicated to gain more functionality and to keep her from regressing.

The MAXIMUS physician reviewer explained that there is little objective information available regarding the effectiveness of work hardening/conditioning/functional restoration, etc. The MAXIMUS physician reviewer indicated that most available literature focuses on back and neck pain as a standard. The MAXIMUS physician reviewer noted that several studies have identified non-medical parameters, which may influence the success or failure of work hardening programs as well as attorney involvement, pain tolerances, and satisfaction with services. The MAXIMUS physician reviewer also noted that there is little information available about end points of work hardening programs besides returning to work and case closure. The MAXIMUS physician reviewer further noted there are few guidelines regarding when the patient who has not achieved these endpoints should discontinue services. The MAXIMUS physician reviewer explained that the strongest work hardening program would be built upon a specific job analysis. However, the MAXIMUS physician reviewer noted that this patient does not have a job to return to. (E Schonstein et al; Cochrane Database Syst. Rev. 2003 (1): CD001822, LS Johnson et al, Work 2001; 16(3): 235-43, Weir R and WR Nielson, Clinic J Pain 2001 Dec; 17(4 Suppl): S128-32, M van Tulder et al, Spine 2000 Nov 1; 25(21): 2784-796). Therefore, the MAXIMUS physician consultant concluded that the requested work hardening program 5 times a week for 6 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,
MAXIMUS

Elizabeth McDonald
State Appeals Department

cc: Texas Workers Compensation Commission

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 10th day of February, 2005.

Signature of IRO Employee: _____
External Appeals Department