

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-2025-01
Name of Patient:	
Name of URA/Payer:	Insurance Company of the State of PA
Name of Provider: (ER, Hospital, or Other Facility)	Injury 1 Treatment Center
Name of Physician: (Treating or Requesting)	Micha Mordecai, DC

July 29, 2005

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,

Michael S. Lifshen, MD  
Medical Director

cc: Injury 1 Treatment Center  
Micha Mordecai, DC  
Texas Workers Compensation Commission

CLINICAL HISTORY

Available documentation received and included for review consists of requestors position on pre-authorization for additional 10 sessions of CPM from Injury 1 Treatment Center, (Phil Bohart, MS, CRC, LPC), CPM records 04/19/05 – 05/12/05. Peer review denials from Genex (Hamby, DC and Holtzman, MD., Eval and treatment notes, Drs. Scott (DO), Mordecai (DC) Electrodiagnostics Harman,(MD)

Ms. \_\_\_\_, a 38-year-old female, injured her lower back while working as a custodian, lifting a vacuum backpack onto her back; she developed an acute onset of sharp pain. She subsequently was followed by a company physician, Dr. Scott who diagnosed her with a lumbar strain. She was evaluated with various diagnostics, treated with physical therapy and epidural steroid injections.

Electrodiagnostic studies performed on 6/15/04 indicated demyelination of the right sural and supraionial sensory and peroneal motor nerves and left sural sensory nerve, indicating bilateral S1 radiculopathy. MRI performed on 2/4/04 indicated a minimal lateral L4/5 disc bulge.

She had a surgical consult in November 2004 which recommended surgery, however this was denied through the peer review process. She was referred for pain management services and has undergone 10 sessions.

The records indicate compliance with attendance, with consisted effort reported by the entire treatment team at the end of the 10 trial sessions. Functional progress was made with an increase in trunk range of motion, lifting and push/pull capacity. ADL improvements were noted in stair climbing, standing and sitting tolerances.

A mixed pattern of improvement was noted on the self reporting assessment scales, with improvements noted on degree of irritability, vocational, financial and claim issues, along with tension and anxiety and sleep and forgetfulness.

Use of hydrocodone medication was reduced with the substitution of OTC Tylenol/Advil.

#### REQUESTED SERVICE(S)

Medical necessity of chronic pain management program, X 10 sessions.

#### DECISION

Approved.

#### RATIONALE/BASIS FOR DECISION

The patient has made demonstrable improvement including functional and psychological gains with the initial 10 CPM sessions. ACOEM guidelines<sup>(3)</sup> suggest focus should be on functional improvement rather than on abolishing pain. The treatment goals for this patient are individualized, functional, objective and measurable.

Review of the documentation supplied supports the patient fulfils the criteria for establishing medical necessity for continuation.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

#### **References:**

1/ CARF Manual for Accrediting Work Hardening Programs

2/ AMA Guides to the Evaluation of Physical Impairment, 4<sup>th</sup> Edition

3/. ACOEM Guidelines Ch. 6 pg 107 & 109

## 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 29<sup>th</sup> day of July 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell