

October 24, 2002

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0073-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

\_\_\_ a 58-year-old male, injured his lower back and neck while working as a dock worker for \_\_\_. When he was attempting to lift carts of film he developed acute onset of low back and neck pain. The low back pain was associated with intermittent radiation into the right lower extremity and with associated numbness and tingling in a nondermatomal distribution. He presented to \_\_\_ and underwent a course of chiropractic/active rehab and medical care, following a diagnosis of lumbosacral segmental dysfunction and displacement of the lumbar intervertebral disc without myelopathy. A functional capacity evaluation was performed 5/17/02. This indicated a valid, consistent effort with tasks discontinued secondary to pain. Psychosocial screening consisted of a Modified Somatic Perception Questionnaire (MSPQ), a Pain and Impairment Relationship Scale (PAIRS), Short Screening Scale for Anxiety and Depression (SSAD) and a substance abuse questionnaire were all essentially normal, aside from the SSAD revealing that the patient has a 50% chance of clinically important disturbance. The FCE revealed the patient was functioning at a light physical demand level category. Recommendations were for continued active rehabilitation for two to three weeks with transition into a work

hardening program. A follow-up FCE was performed on 7/25/02 and identified the patient to be performing in the light-medium PDL. He remained with some limitations concerning repetitive motion activities, with task discontinuation again due to pain. Validity criteria show the patient to put forth good effort without any psychosocial limitations identified. The patient was seen on 7/11/02 for a neurological consult with \_\_\_\_\_. According to his report, a lumbar spine MRI was performed on 4/10/02 and demonstrated lumbar spondylosis throughout, worse at L5/S1 with associated decreased disc height and posterior osteophytic formation with associated bilateral foraminal stenosis and bilateral facet joint hypertrophy. There was associated disc protrusion at L5/S1 apparently to the same protrusion again with associated bilateral foraminal stenosis. Also noted was disc desiccation of both L4/5 and L5/S1 disc spaces. A cervical spine MRI dated 4/10/02 was also reviewed, demonstrating cervical spondylosis throughout, worse at C5/C6 with a 2-3mm diffuse osteophytic formation with resultant bilateral foraminal stenosis. \_\_\_\_\_ impression was of a lumbar spondylosis with lumbago and radiculitis, cervical spondylitis, cervicgia and lumbar myofascial injury. He did not feel that the patient was a surgical candidate and believed that he would benefit from continued physical therapy for symptomatic relief, along with evaluation for epidural steroid therapy with lysis of adhesions if the symptomatology did not abate. There are also two work hardening progress reports, from weeks 7 and 8. These report that the patient functions in the medium physical among level category. Activities include performing box lifts, repetitive bends/overhead reaching and pushing and pulling along with some psychological counseling. There appears to be some progression from 55 lbs. to 65 lbs. between weeks 7 and 8. A discharge functional capacity evaluation was performed on 8/13/02. The patient was placed in a medium physical demand level category, again showing progression with respect to lifting capabilities. No psychosocial issues were identified and the patient demonstrated good effort. Recommendations were made for two further weeks of work hardening for four hours per day, five days a week, cutting currents with a return to work for four hours per day at a medium physical demand level. The request for continued work hardening has been denied for payment based on medical necessity and is thus referred for medical dispute resolution purposes through the IRO process.

#### REQUESTED SERVICE

The request is for two additional weeks of work hardening for \_\_\_\_\_.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The reviewer finds no evidence supporting the requirement of continuing the work hardening program for this patient in the supplied documentation. For all intents and purposes, the work hardening to date appears to have been focused on increasing strength with respect to lifting and repetitive movements. Although the consecutive FCEs show

evidence of improving strength, this could easily have been obtained through a simple kinetic activity-based strengthening/rehabilitation program.

Work hardening involves a multidisciplinary approach and is reserved typically for outliers of the normal patient population, i.e., poor responders to conventional treatment intervention, with significant psychosocial issues and extensive absence from work<sup>(3)</sup>. The sustained injury appears to have been a relatively straightforward lumbar discopathy with sciatica, which responded reasonably well to conservative physical intervention, with some residuals of pain and weakness.

All of the other indicators which would normally identify an appropriate candidate<sup>(3)</sup>, namely the functional capacity evaluations, pain diagrams, reports of treatment participation, indicate that the patient does not require any form of multidisciplinary work hardening, much less further continuation of such a program above and beyond normal work hardening requirements.

There have not been any significant psychosocial or other barriers to recovery identified, with the only indication of any psychosocial involvement coming from one of the battery of psychological screening measures. When taken as a whole, the battery indicates absence of any psychosocial barriers to recovery, and when combined with the remainder of the clinical documentation, supports that these factors are, in fact, completely absent. There was good validity and participation identified in this patient.

Established clinical guidelines<sup>(1,2)</sup> state that an appropriate strengthening/rehabilitation program be instituted to improve mobility and strength deficits following a course of passive care. The reviewer is unaware of any treatment guidelines that suggest work hardening to be a required treatment progression in the absence for clinical indicators for work hardening. The functional capacity evaluations showed patient participation to be valid, with only focal identified weakness to the lower back identified as abnormal (which would be expected in such a patient). Poor/invalid participation with submaximal effort or a mixed picture of effort/participation would generally indicate the requirement for additional intensive treatment provided by work hardening.

In conclusion, according to the available documentation, this patient's continued problems were limited to strength and mobility loss, associated with his lower back injury. No other complicating factors or barriers to recovery are reported or recognized to suggest anything more than the requirement of a focused strengthening/rehabilitation program was necessary.

The patient appears to be fairly close to the physical demand category level required by his work at this point. With appropriate return to work limitations, returning this patient to work would, in fact, be the best "work hardening" for this patient.

As an officer of \_\_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

**References:**

1/ Haldeman S., Chapman-Smith D., Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Gaithersburg, MD, 1993

2/ Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997

3/ CARF Manual for Accrediting Work Hardening Programs

**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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).