

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-03-0076.M2

NOTICE OF INDEPENDENT REVIEW DECISION

July 9, 2002

RE: MDR Tracking #: M2-02-0590-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This 38 year old female sustained a work related injury on ___ when she fell against a door of the restroom, striking her right side. Another report states that she slipped and fell on her back. She underwent an MRI on 07/24/01 and electro-diagnostic studies on 07/26/01. The patient is under the care of ___ and currently complains of head, neck, right shoulder and lower back pain. The treating chiropractor has recommended that the patient undergo a 20 day pain management program.

Requested Service(s)

A 20 day pain management program.

Decision

It is determined that a 20 day pain management program is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation reveals that the patient has undergone an extensive course of treatment that has included manipulation, physical therapy, bursae injections, trigger point injections, medications, neuromuscular stimulator, cryo unit, and 29 work hardening program visits. The patient's work hardening program included elements of a chronic pain management program including group counseling and biofeedback.

Entrance criteria for a chronic pain management program includes whether the patient will benefit from the program. According to TWCC 1996 Medical Fee Guidelines, p.40, entrance criteria includes "persons who are likely to benefit from the program design". In light of the patient's history of treatments related to the ___ work-related injury and his lack of response to care, it is not likely that the patient will benefit from a program of chronic pain management.

This decision by the IRO 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** (10) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **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,