

July 10, 2002

**REVISED**

Re: MDR #: M2-02-0686-01  
IRO Certificate No.: IRO 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a Board Certified Chiropractic Neurologist.

**THE REVIEWER OF THIS CASE AGREES WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.**

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days of your receipt of this decision (28 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 twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you five (5) 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 Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 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.

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 August 20, 2004002.

Sincerely,

This is \_\_\_ for \_\_\_. I have review the medical information forwarded to me concerning MDR # M2-02-0686-01 in the area of chiropractic neurology. The following documents were presented and reviewed.

**A. MEDICAL RECORDS REVIEWED:**

1. Medical Dispute Resolution, \_\_\_ PhD
2. Denial Letter, \_\_\_, 05-08-02
3. Denial Letter, \_\_\_, 04-24-02
4. Request Letter, \_\_\_ PhD, 04-22-02
5. RME Examination, \_\_\_ MD, 03-02-01
6. Review Letter, \_\_\_, 11-15-01
7. Independent Review, \_\_\_, 11-15-01
8. Group and Individual Psychotherapy Daily Notes, \_\_\_ PhD, 04-15-02 to 04-26-02
9. Rehab Status Report and Daily PT Notes, \_\_\_, 04-15-02 to 04-26-02

**B. BRIEF CLINICAL HISTORY:**

The medical records submitted state that the patient was injured on \_\_\_ while she was taking supplies out of a van and putting them onto a cart. She states she felt a sharp pain followed by a dull ache for the rest of the day. She has been treated by several doctors including medications, physical therapy, work hardening, psychotherapy, and chiropractic care.

**C. DISPUTED SERVICES:**

Request for review of denial of 4 weeks/5 days a week chronic pain program with clinical psychologist

**D. DECISION:**

I agree with the decision to deny approval of the clinical psychotherapy.

**E. RATIONAL OR BASIS FOR DECISION:**

In order to receive admission into a chronic pain management program, according to the Commission of Accreditation of Rehabilitation Facilities (CARF) 1994 Standards Manual, the patient must exhibit benefit from the program design, symptoms that meet the description of chronic pain syndrome, and whose medical, psychological, or other conditions do not prohibit participation in the program. The patient has no documented benefit from the program she already participated given the fact that she had little change in her self-rated pain and little change to her ability to deal with stress effectively. Diagnostic reports exhibit degenerative changes that were part of her medical history prior to the accident, this is probably now the cause of her discomfort and not the incident in question. She has been examined by a designated doctor and the conclusion was that she was at MMI, with a 5% Impairment Rating.

**F. DISCLAIMER:**

The opinions rendered in this case are the opinions of the evaluator. This medical evaluation has been conducted on the basis of the documentation provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports, or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.