

## NOTICE OF INDEPENDENT REVIEW DECISION

November 19, 2002

RE: MDR Tracking #: M2-03-0221-01  
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 58 year old male sustained a work-related injury to his neck and back on \_\_\_ when he fell and landed on his head. He has had surgery to his neck, mid and lower back. The last surgery was an anterior interbody fusion at L5-S1, done on 05/06/02. The patient completed a 6-week physical therapy program and a work hardening program. The patient reports that his pain has persisted despite these various treatments. The treating chiropractor recommended a pain management program for 30 sessions.

### Requested Service(s)

Pain management program for 30 sessions

### Decision

It has been determined that a pain management program for 30 session is medically necessary.

### Rationale/Basis for Decision

This patient has had surgeries to both his cervical spine and lumbar spine with post surgical rehabilitation after both. In spite of the extensive physical rehabilitation, the patient still has limitations in strength, range of motion and flexibility. In addition, the patient also has limitations in his activities of daily living. These continued limitations are indications for a chronic pain management program in order to assist the patient in coping with his injuries, both mental and physical. Therefore, a pain management program for 30 sessions is medically necessary.

This decision by the IRO is deemed to be a TWCC decision and order.

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### **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,