

January 31, 2003

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

MDR Tracking #: M2-03-0338-01  
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

\_\_\_ was rear-ended by a school bus on \_\_\_ and was treated at \_\_\_ by \_\_\_ for complaints of neck pain, upper back pain and numbness in both arms. Past medical history reported a 1996 back surgery and right wrist fracture. A diagnosis of cervical sprain and thoracic strain with post-traumatic cephalgia was rendered. Medications were prescribed and he was returned to work. He presented to \_\_\_ when his symptoms did not relent.

#### REQUESTED SERVICE

A pain management program five times per week for six weeks is requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

## BASIS FOR THE DECISION

The documentation provided for review by the \_\_\_ was insufficient to support their request for a chronic pain management program. Supporting information such as medical records from a work hardening program, functional capacity evaluations, and re-examinations by \_\_\_ were not included. There was no plan, no specific short-term and long-term goals to be met, nor was an outline of the proposed pain management program included.

\_\_\_ does not give enough clinical evidence to support his diagnosis rendered on 8/29/02. His appeal letter is passionate, but without objective or clinical data. For example, the Beck Depression Inventory II was not included in the appeal. Also, there was no indication that any other tests, such as MMPI-II were administered.

Regarding \_\_\_ physical complaints, the objective findings from the physical evaluations performed by \_\_\_, \_\_\_ and \_\_\_ do not match the patient's subjective complaints.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

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,

## **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).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 31<sup>st</sup> day of January 2003.**