

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0129-01

IRO Certificate No.: 5259

October 23, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

Available information suggests that this patient experienced an injury to her lower back at work on ___ while bending over to retrieve an object from the floor. She presented initially to ___ with complaints of low back pain. Imaging and lab studies were found essentially negative except for mild degenerative disc changes at L4/5 levels. The patient was given a diagnosis of lumbar strain and given medications upon discharge. The patient later presents to her chiropractor, ___ on or about 6/11/02. X-rays are repeated and again found to be essentially normal with some early degenerative changes at L4/5 segments. MRI is ordered on 6/18/02 suggesting central disc herniations at L3-L5 segments with disc bulging at L5/S1 segment. The patient appears to undergo chiropractic care with multiple PT modalities and is referred for medical assessment with a ____. A 6/27/02 report from ___ suggests findings of lumbar sprain and lumbar HNP with radiculitis. EMG/NCV neurodiagnostic studies are performed 7/16/02 and found essentially normal with some evidence of L5 nerve irritation. Epidural Steroid Injections are performed by ___ on 9/17/02. Chiropractor appears to continue therapy and orders back support and shoe orthotics. The patient is referred for pain management evaluation with ___ on 2/14/03 and was found with no neurological deficit but with some discogenic pain. ESI's and additional medications are again ordered with recommendations to continue therapy and rehabilitation. An RME is performed 2/20/03 by a ____, suggesting lumbar degenerative disc bulges at multiple levels with no evidence of radiculopathy. Additional ESI's are performed by ___ on 3/19/03, 3/26/03, and 4/2/03. Lumbar facet joint injections appear to be performed 5/27/03 and 5/28/03 with SI joint injections performed 5/21/03 and 5/28/03 as well.

The patient begins a work hardening program with ___ and undergoes psychological assessment with a ____. An 8/15/03 follow-up report submitted by ___ suggests that this patient be seen for orthopedic surgery assessment and be considered for chronic pain management if surgery is not opted. A functional capacity evaluation is performed by another chiropractor on 8/26/03 but no orthopedic surgical consultation appears to be performed. Chiropractic work hardening notes submitted 9/8/03, 9/9/03, 9/10/03 and 9/11/03 suggest that the patient has made significant progress with functional program and is expected to return to work with completion of program. However, there is a 10/6/03 chiropractic report from a third chiropractor, ___ suggesting that the patient has completed all conservative treatment with poor results and has exhausted all means of care except chronic pain management program which is now requested.

REQUESTED SERVICE (S)

Determine medical necessity (prospectively) for proposed 30 sessions of chronic pain management program.

DECISION

Deny request. Available documentation does not support medical necessity for chronic pain management program at this time.

RATIONALE/BASIS FOR DECISION

There is no documentation submitted in this file suggesting that the patient has been evaluated by a qualified orthopedic surgeon or other qualified spine surgeon. As requested by pain management specialist, ___ this evaluation would appear indicated before chronic pain management program would be considered reasonable and appropriate. In addition, there appears to be a considerable conflict of findings documented from chiropractic reports of ___ (treating doctor) and ___ (who does not appear to have performed an examination of this patient submitted for review).

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.

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** (ten) calendar days of your receipt of this decision (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 this 28th day of October 2003.