

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0444-01  
IRO Certificate No.: 5259

January 13, 2004

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 \_\_\_.

Notice of Independent Review Determination

### CLINICAL HISTORY

\_\_\_ was lifting a pallet at work on \_\_\_ when she felt a sharp pain in her back. She went to see \_\_\_ for her symptoms and received medication as well as three months of passive and active therapy. She was placed on work restrictions, however it appears the employer did not adhere to these restrictions and her condition worsened. Due to her condition worsening, she was forced to take a leave of absence. She continued with therapy with \_\_\_\_, however no further diagnostic procedures were done. On 8/1/03 she changed her care to \_\_\_ and \_\_\_\_. On 8/1/03 \_\_\_ examined the patient and found pain with associated myospasm and tenderness in the lower back region along with restricted range of motion on many of the orthopedic tests. His recommendations focused on active therapies for strengthening and conditioning and reduction of pain and spasm. Also suggested was a medical consultation with \_\_\_\_. On 8/3/03 \_\_\_ examined the patient and found that she qualified for an Interdisciplinary Pain Management Program by meeting twelve (12) of the factors set forth in the Mental Health Guidelines, Medical Fee Guidelines. On 8/21/03 \_\_\_ examined the patient and recommended active therapy to address deconditioning as well as advancement

into a work hardening program when appropriate. He also recommended psychological counseling for depression and pain control when available. On date 8/21/03 \_\_\_ noted her pain level at 9 on a scale of 0-10, the pain was constant. Also noted was a reduction in DTR's in the patella region bilaterally and reduction of L4 and L5 dermatones. \_\_\_ suggested strengthening and stretching for her deconditioned state and moving her into a work hardening program at an appropriate time. He also suggested psychological counseling for depression and pain control along with continued orthopedic consultations. MRI performed 9/12/03 showed no significant abnormalities.

#### REQUESTED SERVICE(S)

Prospective medical necessity of the proposed Chronic Pain Management Program x 30 sessions.

#### DECISION

Approved.

#### RATIONALE/BASIS FOR DECISION

TWCC Guidelines Rule 408.021 allows the patient to receive care for this injury. After reviewing the information provided and the reports from four individual examinations, all of which recommend the same course of care and without seeing any information that would suggest any other course of action, the requested services for care are medically necessary and legally demanded. The clinical history noted above is only a brief summation of the information provided. After reviewing the exams extensive, it is appropriate and medically necessary for the requested care to be provided.

### **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 14<sup>th</sup> day of January 2004.