

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-04-2214.M2**

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

MDR Tracking Number: M2-04-0530-01  
IRO Certificate Number: 5259

December 15, 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

After being injured at work on \_\_\_ when a tote bag fell on her right shoulder, patient received extensive treatment for her injuries including chiropractic care, physical medicine procedures, medications and injections.

REQUESTED SERVICE (S)

Prospective medical necessity of the proposed Chronic Pain Management Program consisting of 30 visits over a 6-week period.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Based on the voluminous medical records and examination reports submitted by multiple doctors, the proposed chronic pain management program is not medically necessary. This position is supported by the examination report of board certified Physiatrist \_\_\_ (March 6, 2002) that did not include the disputed item in his further care recommendations; the examination report of "designated doctor" \_\_\_ (March 5, 2003) that did not

include the disputed item in his further care recommendations; and the examination report of \_\_\_ (August 11, 2003) that referenced the patient's "marked symptom magnification" and opined that the patient "does not need future treatment..."

### **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 15<sup>th</sup> day of December 2003.