

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0707-01  
IRO Certificate Number: 5259

January 23, 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 \_\_\_.

### CLINICAL HISTORY

Patient reported work injury of \_\_\_ when, as being evacuated from a building stepped on a curb and fell. Patient stated she struck her right extended wrist and right knee, jarred her neck and shoulder and immediately experienced wrist and low back pain.

### REQUESTED SERVICE(S)

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

### DECISION

Denied.

### RATIONALE/BASIS FOR DECISION

After multiple surgeries, multiple interdisciplinary referrals and extensive physical medicine modalities over a three-year time period, the patient's pain remains essentially the same. This extensive treatment has had within it the self-help strategies, coping mechanisms, exercises and

modalities that are inherent in and central to the proposed chronic pain management program.

In other words and for all practical purposes, most, if not all, of the proposed program has already been attempted and failed. Therefore, since the patient is not likely to benefit in any meaningful way from repeating treatments already rendered, the chronic pain management program is medically unnecessary.

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