

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0756-01

IRO Certificate No.: 5259

February 16, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in neurology. 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

A 39-year-old female with work related injury on ___ bending over moving a bundle of clothes. Initially this was neck and left wrist pain. Subsequently the patient developed low back symptoms. She underwent work hardening along with group therapy apparently on a daily basis. She underwent L5-S1 laminectomy with interbody fusion. A bone stimulator was subsequently required. She then underwent L4-5 and L5-S1 radical discectomies with interbody fusions and insertion of cages in October 2000. She has continued to have pain and psychological changes secondary to the chronic pain.

REQUESTED SERVICE (S)

Chronic pain management program for 30 sessions.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The patient is appropriate for participation in a comprehensive behaviorally based pain management program. Work hardening with group therapy is not the same as a chronic pain management program. Even if it were extensive, surgical treatment has been performed since the work hardening. Chronic pain management is medically indicated and necessary for this patient.

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 19th day of February 2004.