

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0980-01

March 29, 2004
IRO Certificate# 5259

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 53-year-old male injured on the job on ___ while riding a lawn mower which overturned. He sustained a comminuted nasal fracture, head injury, cervical strain, and acute contusion of the hand. Physical therapy achieved limited success. There was continued complaint of pain, headache, and limited function. Situational depression ensued. MRI of the cervical spine performed 8/13/03 revealed mild degenerative change at C3, C4, C5, and C6. There have been many requests for a comprehensive pain management program. Those requests were denied but outpatient psychotherapy and biofeedback were approved individually. EMG 10/10/03 by ___ revealed right Cubital Grove Syndrome entrapment right ulnar groove at the elbow, no evidence of radiculopathy. The patient has continued to fail to rehabilitate back to work in a timely manner and has persistent headaches, pain in the hand, and has been considered to continue to represent a high risk to be returned to truck driving.

REQUESTED SERVICE (S)

Chronic pain management program x30 sessions

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

This patient needs to have education. He needs to have his ideas of chronic pain re-conceptualized from an acute to a chronic model.

This follows from, as has already been expressed, former TWCC treatment guidelines and CARF guidelines.

Physical and psychological complaints need to be addressed simultaneously and not individually or piecemeal as has been done heretofore. A chronic pain program would have been the most likely way to have already returned this patient to the active work force.

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 29th day of March 2004.