

NOTICE OF INDEPENDENT REVIEW DECISION

June 9, 2004

MDR Tracking #: M2-04-1095-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 50-year-old patient was injured on the job on ___ when he fell eight feet from a ladder. He sustained a broken back, fractured pelvis and concussion from the fall. The documentation states that the patient was having trouble with walking, standing, laying down, lifting, sitting, bending, twisting and stooping and with activities of daily living such as driving, sleeping and performing household chores, etc. The patient's treatment plan included chronic behavioral pain program and medications.

Requested Service(s)

Chronic pain management program for ten sessions

Decision

It is determined that the chronic pain management program for ten sessions is not medically necessary for this patient's condition.

Rationale/Basis for Decision

The medical records provided fail to substantiate that the most recently attempted chronic pain management program of twenty sessions was beneficial. Specifically, the patient obtained no significant relief from the treatment on the basis that his pain rating only decreased from nine to eight when the stated goal was "three to four".

The treatment did not promote recovery on the basis that the Global Assessment of Function (GAF) scores only improved from 58 to 64 when the stated goal was 85 and the treatment did not enhance the employee's ability to return to or retain employment. Since the proposed program had already been attempted and failed, it is highly unlikely that the patient would benefit in any meaningful way from repeating the same treatments. Therefore, the chronic pain management program is medically unnecessary.

This decision by the IRO is deemed to be a TWCC decision and order.

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 (28 Tex. Admin. Code 142.5 (c))

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 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for 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, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

<p>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 9th day of January 2004.</p>
