

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-1292-01

IRO Certificate Number: 5259

June 28, 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 Texas Medical Foundation, 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 ___.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing work related injury on ___ while lifting an 80 lb. box. He apparently slipped and fell, injuring his back and left leg. He has apparently completed conservative management and not significantly improved. Name and specific orders from treating physician are not provided for review. The patient has apparently completed initial 2 weeks of chronic behavioral pain management and has experienced some improvement in coping skills. Subjective pain levels are minimally reduced. GAF score is increased from 55 to 58. Sleep duration has

increased from 3-4 to 4 ½ hours per night. Activity levels have increased from 0 to 20 min. The patient appears to have demonstrated good motivation and compliance. Issues of anxiety and depression do appear to be appropriately addressed. The patient also notes a decrease in use of pain medications and appears to require these only for flare-ups at this time.

REQUESTED SERVICE(S)

Determine medical necessity for chronic behavioral pain management program (5x per week for 2 weeks) x10 sessions.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Available documentation does support medical necessity for chronic behavioral pain management program of this nature. Though documented improvement levels do appear slow and minimal, there does appear to be evidence of engaged participation and progressive functional improvement. This next phase of intervention also appears to include RTW job simulation, conditioning and vocational counseling. This plan does appear achievable and oriented toward maximum medical improvement.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

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 28th day of June, 2004.