

MDR Tracking Number: M2-04-1322-01
IRO Certificate # 5259

May 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 ___ 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 is a 49-year-old male who was driving a company vehicle, delivering TVs, when he evidently lost consciousness. He ran off the road, and when he awakened, he was in a culvert and his truck had apparently rolled several times. He was transported by ambulance to ___, complaining of right shoulder pain, right hip pain, and right hand pain. He was x-rayed and released with a prescription for pain. He was seen by several medical doctors for physical therapy, chiropractic treatment, and medication but eventually underwent right rotator cuff repair surgery in 08/03. He was then referred for a psychological consultation to determine the absence or presence of psychological overlay. Past medical history is significant for diabetes and high blood pressure, both for which he receives medication.

REQUESTED SERVICE (S)

Prospective medical necessity of a chronic pain management program 5 times per week for 6 weeks (30 sessions)

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

It is the generally accepted standard of care that a chronic pain management program be the last resort in patient care, and utilized only when all other options have been explored and proved unsuccessful. In this case, there is significant indication that the patient is in need of a second right shoulder surgery. Specifically, refer to daily progress note from ___ dated 04/20/04 that reported that the "repeated MRI on the right shoulder stated there was significant amount of scar tissue in there" and that ___ was "anticipating going in there arthroscopically and removing the scar tissue," but it "was denied by the carrier." In addition, according to the medical records, the patient continues to have significant pain in his cervical spine with a positive MRI in that region, as well, that may need surgical intervention at some point. Therefore, for the above reasons, a chronic pain management program at this time is premature. (NOTE: Should the carrier maintain its refusal for additional surgical procedures on this patient, then a chronic pain management program would be medically necessary.)

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 2nd day of June 2004.