

MDR Tracking Number: M2-04-1326-01

June 8, 2004

IRO Certificate# 5259

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

Available information suggests that this patient reports an injury to her knee when she fell on a concrete floor while performing work related duties on \_\_\_\_. The patient presented initially to \_\_\_\_, and was found with lateral meniscus tear, patellofemoral chondromalacia and ligamentous instability. Arthroscopy and synovectomy was performed 09/12/02. The patient then underwent extensive physical therapy with \_\_\_ follow-up with \_\_\_ suggests a post-operative diagnosis of post-traumatic osteoarthritis of the left knee. The patient is placed at MMI on 03/06/03 with a 10% WP impairment rating. In 2004 the patient begins seeing a chiropractor and another orthopedic surgeon and appears to receive additional physical therapy, injections, medication management, work hardening and work conditioning. The patients' pain levels and functional status does not appear to be improved with this intervention. A behavioral health evaluation is made on 03/12/04 suggesting that the patient is experiencing depression and anxiety due to inability to return to work without pain. A two week, multidisciplinary, outpatient chronic pain management program is recommended in order to help the patient develop coping skills and manage pain behavior and dependence on medication.

#### REQUESTED SERVICE (S)

Chronic Behavioral Pain Management Program x 10 Sessions

## DECISION

Approved.

## RATIONALE/BASIS FOR DECISION

Available documentation does support medical necessity for chronic behavioral pain management program of this nature.

History and behavioral health evaluation suggests that there were no significant pain or functional problems reported prior to injury of \_\_\_\_\_. Multiple attempts to return to work have been made but increases in pain and functional limitations are consistently documented.

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 9<sup>th</sup> day of June 2004.