

## **NOTICE OF INDEPENDENT REVIEW DETERMINATION**

MDR Tracking Number: M2-04-1600-01  
IRO Certificate Number: 5259

July 29, 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

Patient received physical medicine treatments and psychological counseling after sustaining injury by lifting a 24-pack of water bottles at work on \_\_\_.

### REQUESTED SERVICE(S)

Chronic Pain Management Program for 30 days.

### DECISION

Denied.

### RATIONALE/BASIS FOR DECISION

The previously attempted physical medicine treatments and psychological sessions had within them the self-help strategies, coping mechanisms, exercises and modalities that are inherent in and central to the proposed chronic pain management program. In other words and for all practical purposes, most – if not all – of the proposed program has already been attempted and failed. Therefore, since the patient is not likely to benefit in any meaningful way from repeating unsuccessful treatments, the chronic pain management program is medically unnecessary.

It is also important to mention that the treating doctor on 07/07/04 determined the patient to have reached clinical MMI. Based on that determination, it is highly unlikely that the proposed chronic pain management program would offer any significant benefit or materially improve the patient's condition.

## 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 2<sup>nd</sup> day of August, 2004.