

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NUMBER:  
SOAH DOCKET NO. 453-05-4089.M2**

**MEDICAL REVIEW OF TEXAS**

[IRO #5259]

**3402 Vanshire Drive**

**Austin, Texas 78738**

**Phone: 512-402-1400**

**FAX: 512-402-1012**

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

TWCC Case Number:	
MDR Tracking Number:	M2-05-0405-01
Name of Patient:	
Name of URA/Payer:	American & Foreign Insurance Co.
Name of Provider: (ER, Hospital, or Other Facility)	North Texas Pain Center
Name of Physician: (Treating or Requesting)	Dr. P, DC

January 10, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

Medical Director

cc:

North Texas Pain Center  
Dr. P, DC  
Texas Workers Compensation Commission

#### CLINICAL HISTORY

This is a lady who reportedly sustained a left upper extremity injury in \_\_\_\_\_. The diagnosis offered was lateral epicondylitis and ulnar neuritis. This was treated surgically. It is unclear how this surgical lesion came under the care of a chiropractic provider. That point notwithstanding, additional pain management techniques were attempted all to no avail. A chronic pain management program was requested and 15 sessions had been completed. The request is for an additional 15 sessions.

#### REQUESTED SERVICE(S)

Medical necessity of the proposed 120-hours of chronic pain management.

#### DECISION

Denied.

#### RATIONALE/BASIS FOR DECISION

The most recent literature (Clinical practice guidelines for chronic non-malignant pain syndrome patient II: An evidence-based approach, J Back Musculoskeletal Rehabil 1999 Jan 1) indicates that the maximum efficacy is with 20 sessions of CPMP. In that 15 sessions have been completed, an additional 15 sessions would be considered excessive and not reasonable and necessary care for the injury sustained. Moreover, after the first week, the progress had plateaued and no real improvement was noted. This would speak against any additional treatment even to reach the 20 session mark. Simply because the standard is there is not a reason to provide all that care if there is no measurable improvement in the prior two weeks.

## 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 12<sup>th</sup> day of January 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: