

# 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:	M2-05-0517-01
Name of Patient:	
Name of URA/Payer:	Tristar/SAISD
Name of Provider:	Positive Pain Management
<small>(ER, Hospital, or Other Facility)</small>	
Name of Physician:	Dr. D, MD
<small>(Treating or Requesting)</small>	

January 4, 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:

Positive Pain Management

Dr. D, MD

Rosalinda Lopez, Texas Workers Compensation Commission

#### CLINICAL HISTORY

Records reviewed included:

1. South Texas Spinal Clinic, P.A. notes from 12/15/03 through 8/20/04;
2. Positive Pain Management notes from 5/13/04, 8/13/04 and 10/5/04;
3. Electrodiagnostic evaluation from 8/27/03 (no radiculopathy); and
4. Dr. P, MD, evaluation on 9/9/03.

64-year-old female status-post work related injury on \_\_\_\_\_. She developed chronic low back and right lower extremity pain. Of note is that she has a prior (8/1999) L3-S1 fusion with instrumentation.

#### REQUESTED SERVICE(S)

Chronic pain management program (30 days).

#### DECISION

Approved. Reverse prior denial.

#### RATIONALE/BASIS FOR DECISION

This chronic pain interdisciplinary program is well suited to the chronic pain syndrome patient. The literature to support such a program can be found in Dr. Aronoff's *Principles and Practice of Pain Management*; Dr. Deyo, JAMA 250:1057-1062, 1983; and Drs. Fordyce and King numerous pivotal peer reviewed references. Upon review of the aforementioned literature, it is clear that there exists positive and current peer reviewed literature for chronic pain interdisciplinary programs.

## 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 18<sup>th</sup> day of January, 2005.

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

Printed Name of IRO Employee: