

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0574-01
Name of Patient:	
Name of URA/Payer:	Zurich American Insurance Co.
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. M, DC

January 12, 2005

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

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:

Dr. M

Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services, Adverse Determination Letters from Carrier
2. Office notes from treating medical doctor (various dates) and script from same to "assess for chronic pain mgmt program," dated 09/28/08 <sic>
3. "Patient Progress Notes" from treating doctor of chiropractic for dates of service 05/25/04, then regularly from 08/06/04 through 10/12/04, with 2 "Physical Therapy Evaluation" reports dated 07/30/04 and 09/07/04
4. MRI reports of lumbar spine, dated 10/11/02, 09/05/03 and 03/26/04
5. Pre-authorization request form for Chronic Pain Management program, dated 11/11/04
6. Psychological evaluation report, dated 10/22/04

Patient is a 39-year-old male utility worker who, on ____, was injured while working in a ditch. At the time, a coworker rolled a bundle of weather stripping down into the ditch which struck the patient in the back and caused him to fall and roll under a stationary parked truck. His roll was stopped when his back struck a rock. He had immediate pain and swelling in his right knee, and his lower back felt "unusual." He presented himself the next day to the local hospital for treatment, but eventually presented himself to Dr. V, M.D., for a trial of conservative care to include chiropractic and physical therapy. Despite these treatments, the patient eventually underwent a 2-level 360 fusion at L4-5 and L5-S1, with a one-level posterior lumbar interbody fusion at L3-4 with instrumentation on 10/27/03. Then, on 12/09/03, the patient underwent a two-level redo laminectomy at L2-3 and L3-4 and a redo posterior lumbar interbody fusion at L3-4, followed by additional post-operative therapy.

REQUESTED SERVICE(S)

Prospective medical necessity of the proposed chronic pain management program.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

In this case, the medical records submitted adequately documented that a compensable injury to the lower back occurred and that the patient underwent 2 spinal surgeries as a result of his injury.

However, upon careful review of the patient progress notes supplied by the physical therapist/treating doctor of chiropractic, the patient was responding well to the care prescribed. Specifically, in the daily notes from August 2004 through October 2004 – right around the time the chronic pain management program was being proposed – the daily notes repeatedly stated, “Cont current plan [secondary] to good response.” In addition, these same records reflect that the patient’s stated pain levels went from a “7” on 08/06/04 to a “5” on 10/07/04. And finally, the “objective” sections of the patient progress notes indicated on multiple occasions that the patient met his therapy goals (eg., on 09/15/04, the record stated “Excellent improvement in lumbar stabilization and paraspinal strength – pat has achieved goal #1”), and that active range of motion was improving (eg., on 10/12/04, the record stated, “Good [increase] in AROM.”

Therefore, since the patient’s current treatment plan appears to be yielding the desired results, the proposed chronic pain management program is premature and its medical necessity is not supported.

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 13th day of January, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: