

NOTICE OF INDEPENDENT REVIEW DECISION

July 9, 2002

RE: MDR Tracking #: M2-02-0765-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 30 year old male sustained a work-related injury on ___ when he slipped on a wet cement floor injuring his lower back. The patient had the following treatments: lumbar epidural steroid injection under fluoroscopy on 07/12/01, L5-S1 lumbar epidural steroid injection under fluoroscopy on 08/14/01 and 09/11/01, diagnostic and provocative discogram at L3-L4, L4-L5, and L5-S1 levels, and an intra-discal electrothermal therapy at L3-L4 and L5-S1. The patient currently complains of mid to low back pain and the treating anesthesiologist is recommending that the patient undergo chronic pain management.

Requested Service(s)

Chronic pain management program

Decision

It is determined that the chronic pain management program is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

There is no medical evidence of any psychological problems or impact on the patient's clinical course prior to the referral by ___ to his pain program. The initial consultation on 06/20/01 documented "patient coping well with stress", with no documentation in any subsequent notes of a change in the patient's psychological status. The patient was deemed sufficiently psychologically stable to undergo multiple invasive procedures, none of which provided any significant benefit, as of 8 weeks ago. The 2 psychiatric evaluations were both too superficial and cursory to be diagnostic or indicative of any psychological problems to justify a chronic pain management program. Both were essentially a listing of the subjective complaints only. Neither included objective tests, personality profiles, or validity testing. There is no documented medical indication for a chronic pain management program for this patient. He does not have a condition that a chronic pain management program is likely to significantly help.

This decision by the IRO is deemed to be a TWCC decision and order.

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 (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

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) 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 (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,