

NOTICE OF INDEPENDENT REVIEW DECISION

February 19, 2003

RE: MDR Tracking #: M2-02-0834-01
IRO Certificate #: IRO 4326

The ___ 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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 27 year old female sustained a work-related injury on ___ when she attempted to move a refrigerator and she felt a sharp pain in her lower back. Lumbar and cervical x-rays performed on 09/13/01 were reported as normal. Thoracic x-rays revealed early spondylosis of the thoracic spine. An MRI of the lumbar spine performed on 09/27/01 revealed an L5-S1, 4-5mm, broad-based, posterior, subligamentous herniation and annular tear with patent foramina. Nerve conduction velocity, evoked potential studies, and needle electromyography studies performed on 10/08/01 revealed no evidence of lumbar radiculopathy, lumbosacral plexopathy, or distal mononeuropathy of the lower extremities. The patient continues to complain of persistent pain and it is felt that she is having chronic pain. The treating physician has recommended that the patient undergo a multi-disciplinary pain management program.

Requested Service(s)

20 day multi-disciplinary pain management program

Decision

It is determined that the 20 day multi-disciplinary pain management program is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient was injured on ___ and received active and passive therapies, injections, and medications with only minimal response to treatment. Chronic pain syndrome is defined as a set of verbal or non-verbal behavior that involves enduring pain, differs significantly from the worker's pre-injury status, has not responded to previous medical or injection treatments, and interferes with the worker's physical, psychological, social, and or vocational functioning. This patient meets this criteria and is a candidate for chronic pain management. Therefore, the 20 day multi-disciplinary pain management program is medically necessary.

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,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

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 19 th day of February 2003.
