

NOTICE OF INDEPENDENT REVIEW DECISION

September 25, 2002

RE: MDR Tracking #: M2-02-0964-01
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 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 42 year old male sustained a work related injury on ___ when he injured his back while putting cable in a machine. An MRI of the lumbar spine revealed disc bulging at L4-5 and L5-S1. The patient complains of continued back pain and following a psychological evaluation, it was recommended that the patient undergo a 20 day pain management program.

Requested Service(s)

20 day pain management program

Decision

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

Rationale/Basis for Decision

The patient has been off work for one year with chronic low back pain unresponsive to chiropractic treatment, passive modalities, TENS, rehabilitation, epidural steroid injections, medications, or group counseling. A psychological evaluation identified that the patient has problems coping and borderline symptoms of depression, as well as symptoms of anxiety.

In view of this patient not being a surgical candidate and the presence of signs and symptoms consistent with chronic pain syndrome, the 20-day chronic 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,