

October 31, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.1032.01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Pain Management and Anesthesiology.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

Clinical History:

This 38-year-old female suffered a work-related injury on ____. She has been diagnosed with cervical and lumbar radiculopathy, multiple lumbar and cervical disc protrusions, but no evidence of nerve compression or surgical pathology. She presently complains of chronic pain in the back, neck, head, arms, hands, legs, shoulders and foot. Psychological evaluation documents depression, anxiety and poor coping skills.

She has been aggressively treated with passive and active rehabilitation, work hardening and conditioning, injection therapy and subsequent medications, including Soma, Valium and Zoloft. It is noted that the patient is 5 ft. 0 in. tall, weighing 225 pounds.

Disputed Services:

Chronic pain management program for twenty days.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the program in question is medically necessary in this case.

Rationale for Decision:

This patient has a long-term chronic pain syndrome that has not responded to comprehensive and long-term conservative treatment. Her long-term prognosis is poor. She is not a surgical candidate, and no medical interventions will likely be of benefit to her. It is likely that she is substance-dependent. Her body habitus and potential for secondary gain further complicate the prognosis. The psychological evaluation reveals the expected depression, anxiety and poor coping skills. An intensive 8-hour-per-day, 20-day period of a pain management program may be the only remaining modality reasonable for this patient. She should be offered the treatment that exhausts all reasonable therapies that can be provided at little or no risk. If this program fails, she will likely be forced to experience the full, natural course of her pain constellation.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days of your receipt of this decision (28 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 twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 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.

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 October 31, 2002.

Sincerely,