

## NOTICE OF INDEPENDENT REVIEW DECISION

December 9, 2002

RE: MDR Tracking #: M2-02-1055-01  
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 \_\_\_ 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 37 year old female sustained a work-related injury on \_\_\_ when she was lifting a crate and lost her balance, straining her left hand and landing on her left knee. Previous treatment applications have consisted of chiropractic care, physical therapy, medications, facet injections, biofeedback, epidural steroid injections, and lumbar sympathetic blocks. The patient currently complains of neck pain, lumbar pain, wrist pain, and left arm and shoulder pain. The treating doctor is recommending that the patient undergo a multi-disciplinary pain management program.

### Requested Service(s)

Multidisciplinary pain management program

### Decision

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

### Rationale/Basis for Decision

The medical record documentation indicates that this patient has undergone numerous passive, active, and invasive applications of treatment in order to resolve her complex pain. The patient has not reported anything more than temporal relief with any of the applications that have been performed. A treatment would be considered a failure if the patient complains of persistent intensity of symptomatology after the treatment application and been rendered.

A tertiary level of care application does not always need failure at the previous two levels of care. A tertiary level of care can be activated as early as 3 months post injury, as referenced in "Unremitting low back pain"; North American Spine Society phase III clinical guidelines for multidisciplinary spine care specialists, published in 2000. All of the screening performed prior to the request for chronic pain management applications identified numerous psychosocial issues that are absolutely relevant in treating this patient's pain. The provider's decision to involve a greater behavioral focus in the patient's rehabilitative care is

medically necessary to treat her condition. Therefore, the multidisciplinary 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,