

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-0986.M2

October 11, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-02-1197-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed DC board certified in Chiropractic Neurology. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

The documentation denotes that the patient was carrying a bundle of shingles weighing approximately 60-70 pounds while working on a roof. He slipped on a leaf and fell from the roof with the shingles landing on top of him. Since his injury of ___, he has had numerous consultations and numerous interventions, including surgeries. The patient is a 58-year-old male who is positive for diabetes. The patient is over four years post injury. He appears to have had some work hardening with psychological care in the past, but there were some compliance issues, and this was long before any of his surgeries.

REQUESTED SERVICE

The treating doctor is requesting chronic pain management for the above referenced injured worker.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The psychological evaluation by ___ reports a GAF of 40 and a major depressive disorder. Severe depression was documented in a psychological evaluation on March 18, 1999. A GAF of 40 is considered severe, extreme or catastrophic by the mental health treatment guidelines and along with the major depressive disorder makes this patient an appropriate candidate for a chronic pain management program. In some cases, a GAF score of 40 or less is a strong indication for possible inpatient treatment. It appears this patient has exhausted all previous avenues and this is his only remaining option. With this patient's advanced age and his limited educational background it is unlikely that he would return to his previous occupation and therefore may require some vocational retraining. Documentation provided meets the criteria for a chronic pain management program as set forth in the mental health treatment guidelines of the TWCC.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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