

NOTICE OF INDEPENDENT REVIEW DECISION

June 3, 2003

RE: MDR Tracking #: M2-03-0164-01
IRO Certificate #: IRO4326

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 patient sustained an injury to her back while lifting a buffer out of a van on ___. She has seen a chiropractor for treatment and therapy. An MRI performed on 12/05/01 revealed an annular tear at L3-4 with slight compression on the thecal sac and a grade I spondylolisthesis at L4-5. The electromyography and nerve conduction velocity studies were both unremarkable. The patient refuses surgery due to fear.

Requested Service(s)

Chronic pain management program

Decision

It is determined that the chronic pain management program is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient had several evaluations by other physicians and epidural steroid injections were recommended but could not be found in the medical record to have ever been tried. No surgical interventions were mentioned. A functional capacity evaluation on 02/13/02 revealed a sedentary physical demand level and that she was 62" tall and weighed 270 pounds. The patient underwent a psychological evaluation on 06/28/02 and the report indicated the patient was experiencing depression, anxiety, and a chronic pain syndrome. A chronic pain management program was indicated because the patient demonstrated a chronic pain syndrome and complex medical condition that had not responded significantly to conservative care.

The medical records reviewed demonstrated no evidence that the patient followed the recommendations of the physicians in this case. The most recent treatment records provided for review were from April 2002 and no current treatment reports were noted. The last clinical report provided was dated 06/28/02. The medical records did not demonstrate that the patient was compliant with the recommendations of the physicians in this case. Therefore, it is determined that the chronic pain management program is not 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,

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 3 rd day of June 2003.
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