

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0237-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 39 year-old female who sustained a work related injury on ___. The patient reported that while at work as a housekeeper, she was moving a basket out of the car when she injured her low back and left and right legs. The patient underwent an MRI that showed dessicated disc at L4-5 with protrusion. The diagnoses for this patient include lumbo-sacral joint dysfunction, lumbar sprain/strain, myositis, and hyperthesia/hypothesia/numbness/parasthesia/tingling. The patient was treated with chiropractic care, oral pain medications, and participated in a pain management program.

Requested Services

Chronic Pain Management Program 5 times a week for 4 weeks.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that case concerns a 49 year-old female who sustained a work related injury to her back and legs on ____. The ___ physician reviewer also noted that the patient underwent an MRI that showed a dessicated disc at L4-5 with protrusion. The ___ physician reviewer indicated that the patient has been treated with chiropractic care, oral pain medications and participated in a pain management program. The ___ physician reviewer noted that the patient has also been evaluated by an outside physician who recommended a discogram to determine if the member was a surgical candidtate. The ___ physician reviewer noted that the patient continues to complain of low back pain with radiation to both legs. The ___ physician reviewer indicated that the patient's chronic pain has left the patient totally disabled. The ___ physician reviewer also indicated that the patient has developed depression and anxiety as a direct result of her injury. The ___ physician reviewer explained that the documentation provided clearly indicates the member to have a chronic pain syndrome due to lumbo-sacral joint dysfunction and degenerative disc disease. The ___ physician reviewer noted that this patient has been fully evaluated and has undergone extensive conservative treatment. The ___ physician reviewer explained that the patient continues with pain associated with depression and anxiety. The ___ physician reviewer explained that the patient has been determined to have a physical/mental impairment greater than expected on the basis of the diagnosed medical condition. The ___ physician reviewer also explained that the patient has pain that has persisted beyond the expected tissue healing time. The ___ physician reviewer indicated that the patient has completed 10 sessions of a pain management program. The ___ physician reviewer explained that the patient would benefit from an additional 20 sessions of pain management. Therefore, the ___ physician consultant concluded that a Chronic Pain Management Program 5 times a week for 4 weeks is medically necessary to treat this patient's condition at this time.

This decision 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 (ten)** 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 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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 23rd day of April 2003.