

NOTICE OF INDEPENDENT REVIEW DECISION

January 24, 2003

RE: MDR Tracking #: M2-03-0250-01
IRO Certificate #: IRO 4326

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 ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ___ physician reviewer 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 41 year old male sustained a work-related injury on ___ when he injured his lower back. A lumbar myelogram performed in June of 1997 revealed a mild degree posterior symmetric annular bulge at L4-5 with annulus excursion uniformly of 4-5mm. Electromyography and nerve conduction studies (EGM/NCS) of the lumbar spine performed in December 2001 revealed evidence consistent with chronic right L5 nerve root irritation, chronic denervation and chronic radiculopathy. EMG/NCS of the cervical spine and bilateral upper extremities in December of 2001 were consistent with chronic right C5 nerve root irritation, partial chronic denervation and chronic radiculopathy. The patient has undergone physical therapy, active rehabilitation, work hardening, and injection therapy. The patient continues to complain of pain and the treating physician has recommended that the patient undergo a multi-disciplinary pain management program.

Requested Service(s)

Multi-disciplinary pain management program.

Decision

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

Rationale/Basis for Decision

Despite conservative care and pain medication, the patient complains of chronic low back pain. An interdisciplinary chronic pain functional restoration program deals with a complex mixture of medical and psychosocial issues. The purpose of this program is to restore function, improve quality of life, reduce pain, and to provide the patient with self-management tools for any residual symptoms. The goal of the program is not to cure the patient of their chronic pain condition. This program has been demonstrated to be both efficacious and cost effective. Therefore, the multi-disciplinary 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,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

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 24th day of January 2003.
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