

## NOTICE OF INDEPENDENT REVIEW DECISION

February 6, 2003

RE: MDR Tracking #: M2-03-0342-01  
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 female sustained a work-related injury on \_\_\_ when she slipped on some water and fell backward on the floor and landed on her buttocks. The patient developed transvaginal bleeding and lumbar pain. An MRI of the lumbar spine and sacrum was performed on 08/14/98. The patient has been treated with epidural steroid injections and pain medication. She continues to complain of pain in the lumbar coccygeal areas radiating down to her bilateral buttocks. The patient also experienced urinary and fecal incontinence. The treating physician has recommended that the patient undergo a pain management program.

### Requested Service(s)

Pain management program, 5 x week for 4 weeks

### Decision

It is determined that the pain management program at 5 x per week for 4 week is medically necessary to treat this patient's condition.

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Rationale/Basis for Decision

This patient has had pain since her injury in \_\_\_ and has developed psychological traits of chronic pain syndrome. The patient is in tertiary phase of specialized care. Psychological evaluation reveals traits such as poor coping, sleep disturbance, anxiety, depression, decreased activity, and a high sense of disability due to the pain. Evidence based approaches to this kind of chronic pain patient show best response from treatment with a 20 day multidisciplinary pain program as long as the patient continues to meet goals throughout the program. The North American Spine Society guidelines recommend a multidisciplinary program at this tertiary stage of treatment. There are occasional exceptions to the 20 day program, and if this multidisciplinary pain center requires a 30 day program, extension should be granted as long as goals are continuing to be met. It should be noted that one of the 13 goals clearly stated is vocational, and returning this patient back to work is an objective of the program. This makes this treatment especially appropriate for this workers compensation patient. Therefore, the pain management program at 5x per week for 4 weeks 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.**

M2-03-0342-01

Page 3

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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 6th day of February 2003.
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