

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0414-01

___ 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 ___ external review panel. This physician is board certified in anesthesiology. ___ 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, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 60 year-old female who sustained a work related injury on ___. The patient reported that while at work she was attempting to pull a patient up in bed, when she experienced immediate low back pain. The patient underwent an MRI and X-Rays of the lumbar spine and EMG. The diagnoses for this patient included discogenic pain, bilateral lumbar facet syndrome, bilateral sacroiliitis and myofascial pain syndrome. The patient has been treated with chiropractic care including manipulations and active rehabilitation that included range of motion stretching, cardiovascular and strengthening exercises. She was evaluated by pain management and referred for epidural steroid injections.

Requested Services

Behavioral Pain Management Program.

Decision

The Carrier's denial of authorization and coverage for the requested services is upheld.

Rationale/Basis for Decision

___ physician reviewer noted that this case concerns a 60 year-old female who sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the patient has undergone evaluation with X-Rays, MRI and EMG testing of the lumbar spine. The ___ physician reviewer indicated that the lumbar X-Rays revealed mild degenerative changes with mild spondylolisthesis. The ___ physician also indicated that the MRI showed a bulging disc in the right neural foramen at L3-4 abutting the L4 nerve root. The ___ physician reviewer further indicated that the EMG demonstrated partial chronic denervation and mild chronic radiculopathy.

The ___ physician reviewer explained that the patient has undergone treatment with chiropractic care including manipulations and range of motion stretching, epidural steroid injection therapy, lumbar facet and sacroiliac injections, and medical analgesic therapy with muscle relaxant, NSAIDS, Hydrocodone and antidepressants. The ___ physician reviewer indicated that the patient continues to complain of low back pain that the patient has reported interferes with her daily living and has rendered her unable to return to work. The ___ physician reviewer noted that the patient has been referred for enrollment into a behavioral pain management program for maximal treatment of her chronic pain syndrome. The ___ physician reviewer explained that the patient has failed to respond to conservative and interventional treatment of her back pain. The ___ physician reviewer indicated that there is no new evidence that intervention is a viable option for long-term pain relief. Therefore, the ___ physician consultant has concluded that behavioral pain management is not 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 25th day of April 2003.