

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-2759.M2

March 14, 2003

AMENDED

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0678-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

CLINICAL HISTORY

Brief History: ___ is a 43 year old female who sustained an injury to her neck and head when she stood up and hit her head on a shelf at work. She states that she blacked out, hit the floor and had to be assisted to her feet by a co-worker. She went home after the incident having intense neck pain. She reported to work the next day and was sent for required blood tests and started seeing ___. She was sent for a CT of the head, placed on light duty and given a prescription to fill when the results of the CT were negative. She complained of pain in her neck, shoulders and back. She was started in physical therapy. After weeks of treatment her pain remained intense, consultation was made with ___ for pain management. Trigger point injections only provided temporary relief. A cervical MRI identified a mild posterior disc bulge at C3-4. She remained symptomatic but was returned to regular duty about 11/4/02. After returning to regular duty she was forced to perform heavy work and her neck and back pain intensified. She became depressed. ___ continued conservative treatment. He prescribed Zoloft and the medication was denied. Trigger point injections were requested and denied. She was taken off work 12/16/02 and has not returned. On follow up she expressed anger towards her supervisor and co-workers

because she felt she was pressured into regular duty work while she was still having pain. She reports that she was told that she would be fired if she didn't return to work. She became depressed and expressed thoughts of suicide. She was referred to chronic pain management program by her treating doctors and was considered an appropriate candidate by ___ for 30 sessions. The carrier did not consider the chronic pain management program medically necessary.

REQUESTED SERVICE

A 30-session Chronic Pain Management Program is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

A 30-session chronic pain management program medically necessary for this patient. ___ treating doctors have established appropriate reasons for entering a chronic pain management program. Chronic pain management programs are designed to help injured workers learn to cope with their pain and to return to their highest level of function.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 14th day of March 2003.