

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-03-2975.M2**

April 1, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0724-01

___ 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 30 year-old female who sustained a work related injury on ___. The patient reported that while at work she slipped in an oil slick and fell injuring her back. The patient underwent an MRI, X-Rays, and CT scan. The diagnoses for this patient include lumbar radicular syndrome with right sciatica, left wrist pain with internal derangement, and cervical sprain/strain. The patient has been treated with oral medications, physical therapy, work hardening, EMG, hot/cold therapy, and electric pulse therapy.

Requested Services

Chronic Pain Management Program

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury on ___. The ___ physician reviewer explained that the patient injured her lumbar spine with pain radiating

into her right leg as well as injuring her right hand. The ___ physician reviewer noted that the patient has undergone evaluations by multiple practitioners and has undergone multiple diagnostic studies including X-Rays, MRI, CT Discogram and EMG. The ___ physician reviewer explained that there was no evidence of significant discogenic disease but on EMG there was evidence of left S1 nerve irritation and bilateral L5 and S1 nerve root irritation. The ___ physician reviewer indicated that the patient was treated with medications, conservative therapy including physical therapy, hot/cold therapy, electric pulse therapy, stretching/exercise, and undergone epidural injection therapy without significant or prolonged pain relief. The ___ physician reviewer noted that the patient has been evaluated by three unrelated facilities, undergoing comprehensive evaluations, with resulting recommendations for a chronic pain management program from all these facilities. The ___ physician reviewer noted that the patient is currently over one year post injury with persistent and severe pain resulting in her inability to work and substantial disability. The ___ physician reviewer explained that the patient is not a candidate for further invasive medical procedures. The ___ physician reviewer also explained that primary and secondary treatments have been attempted and failed. The ___ physician reviewer further explained that the documentation supports that a multidisciplinary approach to address pain and physical limitations in conjunction with emotional and cognitive barriers would provide the best opportunity for long term pain relief. Therefore, the ___ physician consultant concluded that the chronic pain management program 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 1st day of April 2003.