

May 2, 2003

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

MDR Tracking #: M2 03 0789 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.

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

This patient was injured on his job while he was helping to lift a handrail made of steel which weighed over 300 pounds. After carrying it for some distance, reported to be about 50 feet, the crew set the object down and \_\_\_ had an immediate onset of low back pain. Shortly after that, he went to his doctor and was told that he could do nothing for the injury. He was referred to \_\_\_, the current treating doctor. He was prescribed PT and chiropractic manipulative therapy. Treatment also included a work hardening program, which has as a component a group psychotherapy treatment.

#### REQUESTED SERVICE

The carrier has denied the medical necessity of a chronic pain management program.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

While it is certainly possible that this patient has ongoing pain, there is no clear evidence that a chronic pain program would be of use to this patient. The requestor did not submit any documentation as to the patient's current condition. Also, the response to previous behavioral programs would be important.

I question whether a patient who has been through intense group therapy (as in work hardening) would benefit from this program. One must keep in mind that a chronic pain program is not appropriate for every patient. The requestor did state that the patient is depressed, but this is not enough to meet the requirements of medical necessity. A demonstration of high levels of pain combined with a patient's inability to cope and his responsiveness to previous care would be required for medical necessity to be established. The requestor did not meet that goal and I see no reason to presume that the treatment requested is appropriate for this patient.

\_\_\_ 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 2<sup>nd</sup> day of May 2003.**