

June 13, 2003

Re: Medical Dispute Resolution  
MDR #: M2-03-1024-01  
IRO Certificate # 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management.

Brief Clinical History:

This male patient was injured at work on \_\_\_\_. He subsequently developed lumbar and left leg pain for which he underwent microdiscectomy at L3-4 and L4-5, on 01/25/99. Postoperatively, the claimant developed recurrence of lumbar and left leg pain, for which he underwent three epidural steroid injections, unfortunately, with no sustained benefit. An epidural adhesiolysis procedure, as well as bilateral lumbar facet and medial branch blocks at L3-4, L4-5, and L5-S1 were performed, providing no significant pain relief.

Postoperative radiologic studies indicate no recurrence or residual disc herniation, but do indicate the presence of epidural scarring. From the time of his initial evaluation through 02/17/03, the patient has been maintained on Lortab, zero to four daily, as well as Celebrex and Neurontin. His clinical condition, pain complaint, and physical examination have not changed significantly from the time of initial evaluation through 02/17/03. There is no mention in any of the progress notes presented for review of any of the physicians treating the patient for psychological problems, impact on clinical course, or manifestations of psychological illness.

Disputed Services:

Thirty-day chronic pain management program.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that a pain management program is not medically necessary in this case.

Rationale for Decision:

Throughout the almost three years the treating physician has been treating the patient, neither the doctor or the physician assistant have documented any psychological disturbances, psychological impact on the claimant's course, or manifestations of psychological illness. No psychological evaluation or psychological testing is documented in any of the progress notes that would indicate the need for a chronic pain management program.

Progress notes also do not document any attempt at trials of antidepressant or anti-anxiety medications that would, clearly, be a more appropriate first-line treatment than a chronic pain management program, especially with no psychological disturbances noted.

Although the patient continues to experience lumbar and left leg pain, he has not exhausted all appropriate medical treatment. For all the above reasons, he is not an appropriate candidate for a chronic pain management program.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_ is deemed to be a Commission decision and order.

**YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

**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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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.

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 June 13, 2003.

Sincerely,