

May 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1035-01

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The \_\_\_ 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 gentleman who sustained a work related injury on \_\_\_. The patient reported that while at work in the inventory control department he was operating a forklift when he was hit by another forklift. The patient has undergone CT scans, X-Rays and a MRI. The patient has been treated with epidural injections, and conservative treatment that included physical therapy, massage and a TENS unit. The patient has also undergone two spinal surgeries including a laminectomy, he has had a spinal cord stimulator implant, psychological counseling and biofeedback, medical management and participated in a work hardening program. The diagnoses for this patient included lumbar disc displacement, lumbosacral root les nec, lumbar/cervical sprain/strain.

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 this case concerns a 54 year-old male who sustained a work related injury on \_\_\_\_. The \_\_\_ physician reviewer also noted that the diagnoses for this patient included lumbar disc displacement, cervical disc disease, and myofascial pain syndrome. The \_\_\_ physician reviewer further noted that the patient has been treated with physical therapy, massage therapy, analgesic medications, TENS unit, epidural steroid injection therapy, two spinal surgeries, implantation of a spinal cord stimulator, psychological counseling, biofeedback and completed a work hardening program. The \_\_\_ physician reviewer explained that the patient continued to complain of back and neck pain. The \_\_\_ physician reviewer indicated that the patient has a chronic pain syndrome that has been refractory to conservative and interventional treatments. The \_\_\_ physician reviewer explained that this patient's chronic pain syndrome has resulted in a significant situational dysthymia with frustration and anxiety related components. The \_\_\_ physician reviewer noted that this patient's pain management consultant and psychologist both concur that the member requires the specialties of a multidisciplinary chronic pain program to significantly increase his coping skills and control his chronic pain condition. The \_\_\_ physician reviewer explained that this approach will serve to allow his medical practitioners the ability to document his functional limitations as well as to determine ways in which they can more appropriately help him achieve higher functional capabilities from an activities of daily living standpoint. Therefore, the \_\_\_ physician consultant concluded that the requested chronic pain management program is medically necessary to treat this patient's condition.

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 23<sup>rd</sup> day of May 2003.