

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-03-4027.M2**

June 24, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-03-1135-01

___ 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 a board certified anesthesiologist. 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 42 year-old male who sustained a work related injury on ___. The patient reported that while at work he was mopping a ceramic floor when he slipped and fell landing on his back. The patient underwent X-Rays of the cervical spine, thoracic spine and forearm and an MRI dated 3/12/02. The diagnoses for this patient included lumbar intervertebral disc without myelopathy, lumbosacral joint dysfunction, sciatica and thoracic pain. The patient has been treated with pain injections, chiropractic manipulations and has completed a work hardening program.

Requested Services

Chronic Pain Management Program times 30 sessions.

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 42 year-old male who sustained a work related injury to his back on ____. The ___ physician reviewer also noted that the diagnoses for this patient included lumbar intervertebral disc without myelopathy, lumbosacral dysfunction, thoracic back pain and sciatica. The ___ physician reviewer further noted that the patient has been treated with medical therapy, injection therapy, chiropractic manipulations, and the completion of a work hardening program. The ___ physician reviewer explained that despite all treatment the member continues to complain of intense back pain that limits his activities of daily living. The ___ physician reviewer indicated that this patient also underwent a psychological evaluation that determined he is experiencing significant emotional distress as consequence of his work related injuries. The ___ physician reviewer explained that the psychological evaluation has identified health-related stressors (depression, anxiety, inadequate coping strategies to deal with pain, financial worries and psychological stressors) that are considered to be injury related. The ___ physician reviewer explained that this patient has exhausted all other treatments for his chronic pain condition. The ___ physician reviewer further explained that this patient is an optimal candidate for a multidisciplinary, outpatient chronic pain management program. Therefore, the ___ physician consultant concluded that the requested pain management program times 30 sessions 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

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,

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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 23rd day of June 2003.