

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-4453.M2

July 9, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-03-1345-01

___ 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 46 year-old male who sustained a work related injury on ___. The patient reported that while at work he was driving when he drove through a dip in the road. The patient reported that after driving through this dip, he began to experience back and left leg pain. The patient underwent an MRI that showed mild physiological changes and bulging at the lumbar area. The diagnoses for this patient include bilateral facet syndrome and myofascial pain syndrome. The treatment for this patient has included active and passive rehabilitation, physical therapy, chiropractic treatment and medication management.

Requested Services

Chronic pain management program times 30 days.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 46 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer also noted that an MRI of the lumbar spine demonstrated mild physiological bulging and degenerative joint disease. The ___ physician reviewer further noted that the treatment for this patient included medications, active and passive rehabilitation, physical therapy, and chiropractic management. The ___ physician reviewer indicated that the patient continues to complain of pain. The ___ physician reviewer explained that the documentation provided indicated that this patient has evidence of an atypical depression as documented by a psychological assessment. The ___ physician reviewer also explained that there were no abnormalities were noted on a physical exam performed by an orthopedic consultant in 3/03. The ___ physician reviewer indicated that per an MRI and physical exam, there are no findings to indicate that the continued back pain is based on the injury occurred on ___. The ___ physician reviewer explained that the documentation provided indicates that the patient has received maximal treatment to date for the injuries received on ___. Therefore, the ___ physician consultant concluded that the requested chronic pain management program times 30 days is not 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,

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 9th day of July 2003.