

## NOTICE OF INDEPENDENT REVIEW DECISION

July 22, 2003

RE: MDR Tracking #: M2-03-1366-01  
IRO Certificate #: IRO 4326

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a \_\_\_ physician reviewer who is board certified in pain management and anesthesiology which is the same specialty as the treating physician. The \_\_\_ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

### Clinical History

This patient sustained a repetitive injury reported on \_\_\_. She worked on an assembly line and began to experience neck pain. She underwent an anterior fusion at C5-6 and C6-7 in December 2001. The patient did well until she experienced a fall and her pain returned. She started having shoulder muscle spasm and had trigger point injections and a Botox injection.

### Requested Service(s)

Multidisciplinary chronic pain management program

### Decision

It is determined that the multidisciplinary chronic pain management program is medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

The purpose of a multidisciplinary chronic pain management program is to restore function, improve quality of life, reduce pain, and provide the patient with self-management tools for any residual symptoms. This type of program has been demonstrated to be both efficacious and cost effective.

The best objective measures for the study and successful treatment of painful conditions are return to work, increase in activity level, decreased healthcare utilization, and decreased use of opioids.

Flor's study in 1992 showed 24% of the untreated patients or conventionally treated patients returned to work versus 67% of patients treated with an Interdisciplinary Chronic Pain Rehabilitation Program. That report was based on an analysis of 65 studies containing nearly 3100 patients. Therefore, pain rehabilitation programs are twice as likely to return to work as conventionally treated patients (Flor et al 1992 Pain, volume 49, pp 221-230). Therefore, it is determined that the multidisciplinary chronic pain management program is medically necessary.

This decision by the IRO 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** (10) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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,

In accordance with Commission Rule 102.4 (h), 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 22 <sup>nd</sup> day of July 2003.
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