

MDR Tracking Number: M2-03-1438-01
IRO Certificate# 5259

July 16, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ____, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

____ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ____.

CLINICAL HISTORY

This is a gentleman who sustained a lumbar injury in _____. This was not treated surgically and there are a number of degenerative findings in the lumbar spine, and a disc lesion. Additionally, there is a notation of a possible alcoholic syndrome that was never fully explored. A number of interventional pain methodologies were attempted but none achieves any measure of pain control. Over the next several years, the level of narcotic analgesic prescribed rose, in the face of continued "heavy alcohol" use.

REQUESTED SERVICE (S)

30 Days of a chronic pain management program

DECISION

Endorsement of the determination already made.

RATIONALE/BASIS FOR DECISION

Basically there are two questions that are to be answered. Is this reasonable and necessary care for the compensable injury and is there any realistic expectation of success of this protocol? As pointed out by the first reviewer, there does not appear to be any substantive functional limitations in this claimant situation.

Noting that there are chronic pain issues, it would appear that ____ has adjusted as expected and there is little to be gained from this type of program. Moreover there is no indication of any severe psychological situation that is a function of this compensable event. The past alcohol issues do not appear to have been addressed, although there is a reported 1 ½ year period of abstinence.

Thus a multi-disciplinary approach, particularly one that emphasizes psychological issues is not clinically indicated. There does not appear to be much that would be gained by this program. Noting the date of injury, the fact that little if anything has helped (as per ___) and the accommodations already made by this gentleman speaks against the need for the re-training voiced by the requestor. Clearly, this will not change the complaints of pain, will not alter what is needed for this gentleman to exist and is not reasonable and necessary care for the injury sustained.

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) calendar days of your receipt of this decision (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

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 21st day of July 2003.