

November 7, 2003

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
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Austin, TX 78744-1609

MDR Tracking #: M2-03-1776-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

\_\_\_ is a 46-year-old woman who sustained an injury to her lower back on \_\_\_. She received physical therapy from 7/11/01 to 7/25/01 by \_\_\_, PT and from 7/30/01 to 9/17/01 from \_\_\_. On 9/14/01, \_\_\_ provided epidural steroid injections to her lumbar spine and on 9/19/01 \_\_\_ reported the epidural steroid injections were not beneficial and neurodiagnostics were requested. On 9/20/01 \_\_\_ evaluated the employee and he noted that the lumbar spine MRI was positive for annular tears. He provided treatments through 11/16/01. On 10/1/01 \_\_\_ reported neurodiagnostics were negative. On 10/29/01 \_\_\_ reported the employee was diagnosed with lumbar sprain/strain, and on that same day work conditioning was recommended by \_\_\_. On 10/29/01 \_\_\_ performed an IME that determined she was not at MMI. On 11/26/01 \_\_\_ released her to work with restrictions. On 1/7/02 \_\_\_ evaluated her \_\_\_ and recommended therapy three times a week for four weeks and with modified duties. On 2/18/01 modified duty was continued until 3/4/02 when \_\_\_ saw her for \_\_\_ and determined that she would not benefit from any further care. On 5/28/02 \_\_\_ evaluated her from referral from \_\_\_ and reported the discogram was not provocative for the usual pain pattern and surgical intervention was recommended. On 5/30/02 \_\_\_ performed a Designated Doctor evaluation and certified the employee at MMI with a 5% whole person impairment. On 10/4/02 \_\_\_ stated that the surgical intervention would help the

patient's pain. On 10/9/02 \_\_\_ submitted a letter disputing peer review of his treatment. On 11/4/02 \_\_\_ reported that \_\_\_ was not approved for surgery and medications were refilled. On 2/4/03, \_\_\_ did a peer review and stated that this patient had sustained a maximum benefit from therapy services. On 5/21/03 she was evaluated for chronic pain management and she was recommended to be a candidate for chronic pain management. On 8/27/03 the carrier provided peer review by \_\_\_ stating that the chronic pain management program was not indicated because the patient was unable to complete a work hardening program submitted on 6/17/03. On 7/3/03 \_\_\_ submitted an opinion that lower levels of care had not been exhausted, so a chronic pain management program was not clinically indicated.

#### REQUESTED SERVICE

A thirty-session pain management program is requested for this patient.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

\_\_\_ is the type of patient who would most likely benefit from a chronic pain management program. Surgical intervention was denied by the carrier. She has already had ESI's and therapies. The reviewer disagrees with \_\_\_ statement that she was not able to participate in work hardening, therefore she would not be a good candidate for chronic pain management.

Her treating doctors are meeting the standards of care for this injury. The proposed chronic pain management program is medically necessary.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

#### **YOUR RIGHT TO REQUEST A HEARING**

Either party to 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 (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

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

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 7<sup>th</sup> day of November 2003.**