

June 9, 2004

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RE: Medical Dispute Resolution
MDR#: M2-04-1319-01
TWCC#: _____
Injured Employee: _____
DOI: _____
IRO Certificate #: 5055

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: 512-804-4868

Garland Pain Centers
Attn: Nick Kempisty
Fax: (214)943-9407

American Home Assurance Co., c/o Flahive, Ogden & Latson
Attn: Katie Foster
Fax: (512) 867-1729

Mark Laning, D.C.
Fax: (214) 389-9626

Dear Mr. ____:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your care to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc., and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care

provider. Your case was reviewed by a physician who is certified in Chiropractic Medicine and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOBs

Information provided by Requestor: letter of medical necessity, office notes, physical therapy notes, electro diagnostic tests and radiology report.

Information provided by Respondent: correspondence, FCE, radiology report and designated doctor exam.

Information provided by Treating Doctor: office notes and FCE.

Clinical History:

The claimant was involved in a work-related accident on ___ after which he felt immediate pain over his low back. The worker was initially taken to the emergency room where a radiographic series was performed. The claimant was given prescription medication and was released the same day.

The claimant consulted with a chiropractor and underwent evaluation, which revealed an initial impression of a lumbar sprain/strain and left shoulder strain/sprain; trial of conservative chiropractic management including manipulation was implemented.

MR imaging of the lumbar spine was performed on 07/24/02 and revealed a hemangioma at L5 and a small disc protrusion at L5-S1; compression of the thecal sac was not noted. Electro diagnostic testing performed on 11/13/02 revealed findings that were non-suggestive of a radiculopathy.

A pain management specialist evaluated the claimant on 11/14/02; trials of three epidural steroid injections (ESIs) were planned. Required medical evaluation (RME) on 12/01/02 revealed that the claimant was able to return to work and further treatment was not medically necessary. The claimant was initiated into a work-hardening program on 03/31/03.

Psychological evaluation on 04/16/03 revealed that the claimant was a candidate for work-hardening therapy. Psychological evaluation performed on 07/14/03 revealed that the claimant was in a state of depression directly related to his work-related accident. A chronic pain management program was recommended. Evaluation on 03/01/04 revealed that the claimant was a candidate for a 6-8 week chronic pain management program.

Disputed Services:

Chronic behavioral pain management program X 30 sessions.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the pain management program in dispute as stated above is not medically necessary in this case.

Rationale:

The provider has failed to establish a psychosocial baseline of data that warrants the clinical progression of this claimant to upper level therapeutic management for the condition that resulted from the work-related injury that occurred on _____. There is no data that shows any relative history of depression, anxiety, and cognitive deficits that can be reviewed in a qualitative/quantitative manner. On the 03/01/04 behavioral evaluation, the Beck's Depression Inventory showed a score of 35, and the Beck's Anxiety Inventory showed a score of 47. The scores, when initially reviewed, seemed to appear significant; but, there is no chronicity established to warrant the application of a program that is specifically designed to alter apparent pain behaviors. No significant history of apparent pain behaviors have been shown to exist in the reviewed medical documents.

It is not clear why there are no earlier assessments of similar content in the reviewed medical record. The provider's failure to show a baseline and/or behavioral data in a qualitative/quantitative manner will not allow the efficacy of any applied trial of therapeutics to be reviewed in an effective capacity. Further, there are significant typographical errors throughout the behavioral evaluations that tain the reliability of the data generated.

The afore-mentioned information has been taken from the following guidelines of clinical practice and/or peer reviewed references:

- *Overview of Implementation of Outcome Assessment Case Management in the Clinical Practice.* Washington State Chiropractic Association; 2001 54p.
- Richter, P. et al. *Measuring Treatment Outcome by the Beck's Depression Inventory.* Psycho Pathology. 1997; 30 (4): 234-40.
- Wade, J. B. et al. *An Emotional Component Analysis of Chronic Pain.* Pain. 1990. Mar;40 (3): 303-10.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has the right to request a hearing.

If disputing a prospective spinal surgery decision, a request for a hearing must be in writing and must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admn. Code 142.5c).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing and must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admn. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admn. Code 142.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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.

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 US Postal Service from this IRO office on June 9, 2004.

Sincerely,

Gilbert Prud'homme
Secretary & General Counsel

GP/thh