

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

SOAH DOCKET NO. 453-04-1510.M2

NOTICE OF INDEPENDENT REVIEW DECISION

November 12, 2003

RE: MDR Tracking #: M2-04-0250-01
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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional 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 an injury on ___ while trying to stop a full pallet that was rolling loose. He reported pain in his lower back and neck. An MRI dated 03/27/01 revealed a herniated nucleus pulposus at L4-5 and L5-S1. He underwent a two-level lumbar decompression discectomy fusion and spinal instrumentation on 01/23/02. He had been seeing a chiropractor both pre- and post-operatively.

Requested Service(s)

A chronic pain management program of 30 sessions for six hours each for five days per week

Decision

It is determined that the proposed chronic pain management program of 30 sessions for six hours each for five days per week is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Post surgical rehabilitation was attempted but the patient continued to complain of pain. He received some trigger point injections and eventually returned to surgery for removal of hardware on 03/05/03. He also received biofeedback and instructions for a home exercise program.

This patient has undergone a comprehensive treatment program (primary and secondary levels of care) to date as a result of his ___ date of injury. Records and documentation continue to reveal significant subjective symptoms and positive objective findings which necessitate tertiary level of care.

National treatment guidelines allow for a chronic pain management program in cases of surgical failed back syndrome with continuation of significant subjective and objective findings. Such is the situation in this case. Therefore, it is determined that the proposed chronic pain management program of 30 sessions for six hours each for five days per week 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** (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 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, Fax: 512-804-4011.

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

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 12 th day of November 2003.
