

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

SOAH DOCKET NO. 453-04-1511.M2

November 12, 2003

David Martinez
TWCC Medical Dispute Resolution
MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744-1609

MDR Tracking #: M2-04-0278-01
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 Doctor of Chiropractic. 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 39-year-old gentleman who was injured at his job on ___ when lifting an empty pallet from the floor. He initially sought care at ___ where he was prescribed medications. He was taken off of work by the company doctor.

This patient then sought chiropractic care on 5/13/02 with ___ who began active and passive care for this patient's lower back pain. ___ then referred him for an MRI of the low back on 6/2/02 that revealed a 3-4 mm symmetric annular bulge with desiccation of the disc and a mild degree of facet arthrosis at L3/4. There was also noted a 5 mm posterior central disc herniation at L4/5 that indented the thecal sac. The MRI also revealed a moderate degree of facet hypertrophy combined with canal stenosis noted at the L4/5 level.

On 10/2/02 ___ was referred for an EMG of the lower extremities, and it revealed denervation in the right L5 paraspinal muscles, indicative of a right L5 radiculopathy. The patient then underwent an RME with ___ on 10/10/02, and it stated that the patient was not at MMI but could

handle modified duty. He was referred for orthopedic consult on 11/8/02 with ____, who stated the patient should undergo a series of lumbar epidural steroid injections and active physical therapy and possible decompression of the L3/4 and L4/5 levels.

The documentation provided for review states that ____ referred ____ to ____ on 1/16/03 for a series of epidural steroid injections to the lumbar spine. The patient was also noted to have undergone work conditioning and work hardening. The documentation provided states that ____ was referred for a psychological evaluation on 3/20/03. The patient underwent an Designated Doctor's examination on 8/28/03 that stated the patient was at MMI with a 10% Whole Person impairment rating. The patient currently is still under care and there is a question of whether the patient is a candidate for a chronic pain management program.

REQUESTED SERVICE

A chronic pain management program is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The rationale for determining treatment was deducted from the records provided for review. The patient falls well within the Mental Health Guidelines as needed for determining medical necessity of CPM. This determination also falls within the Mercy Fee Guidelines, Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, and well within the mainstream of the medical community.

____ 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 12th day of November 2003.