

November 18, 2003

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

MDR Tracking #: M2-04-0353-01
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

___ suffered an injury to his low back at work while he was changing an 18-wheeler truck tire in ___. He had lower back surgery in February the following year. A designated doctor examination on 2/25/03 stated that he had not reached MMI.

This patient continues to suffer low back and leg pain. His pain is classified as severe pain according to the visual analog pain scale and Oswestry Pain Index. His treating doctor is concerned over this patient's lack of progress and failure to return to work and has referred this patient to a Chronic Pain Management Program (CPMP).

The carrier's position is that there is no need for CPMP, as this patient has already had 37 sessions of post-operative physical therapy and six psychiatric visits. The carrier states that this patient "Needs RTW issues with accommodations & vocational counseling."

REQUESTED SERVICE

A 30-session chronic pain management program is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds that the 30-session CPMP is both reasonable and necessary for ___. There has been no finding of MMI by either the treating doctor or carrier, indicating that this patient can

still achieve some improvement. This program also includes “vocational analysis of return-to-work issues... and other work options are explored,” which is what the carrier has requested.

This review was based on procedures and protocol outlines in the Texas Workers Compensation Act and Rules, specifically section 130.1, and the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters.

___ 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 18th day of November 2003.