

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** February 3, 2004

**RE: MDR Tracking #:** M2-04-0621-01  
**IRO Certificate #:** 5242

\_\_\_ 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 Psychologist reviewer (who is board certified in Psychology). The physician reviewer 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**

The records provided indicate the claimant was injured on \_\_\_ while working for \_\_\_. He and another worker were attempting to lift a heavy steel ladder when he felt a pull in his low back and pain in his legs. He immediately sought treatment at \_\_\_. He then sought treatment with \_\_\_ on 11/1/02. He has been treated by that group since that time. He has received conservative treatment to include chiropractic treatment, individual psychotherapy and biofeedback. He was evaluated by an orthopedic surgeon and found not to be a candidate for surgery. He continues to be unemployed.

### **Requested Service(s)**

Thirty sessions of a chronic pain management program

### **Decision**

I disagree with the carrier and find the procedure is medically necessary.

### **Rationale/Basis for Decision**

The claimant does meet criteria for suitability for a chronic pain management program. He reportedly has completed all primary and secondary levels of evaluation and treatment, which have failed. The fact that services similar to those that are incorporated into the chronic pain management program have been tried separately does not preclude referral to a chronic pain management program. This issue has been addressed at previous TWCC hearings. It has generally been decided that a chronic pain management program that is multidisciplinary and provided in the same facility is considered to be tertiary treatment and can be provided if believed to be potentially effective.

Therefore, based on the fact that the claimant is a suitable candidate, that the program meets criteria for a multidisciplinary chronic pain management program, and both the diagnosis and the requested frequency and duration of the program fall within clinical guidelines, it is my opinion that the request for a chronic pain management program is medically necessary.

## 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 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.