

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

SOAH DOCKET NO. 453-04-3630.M2

January 28, 2004

Re: MDR #: M2-04-0630-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ 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 ___ 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.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management.

Clinical History:

The records indicate the patient was injured on ____. He underwent intensive chiropractic care, passive and active therapy, as well as medication and injections. An MRI of the lumbar spine reveals significant disc involvement. The patient's condition continued, which necessitated lumbar spine surgery. The patient completed post surgical rehabilitation program. The patient has also had a functional capacity evaluation and behavioral assessment.

Disputed Services:

Chronic pain management program X 15 sessions.

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the pain management program in dispute is medically necessary in this case.

Rationale:

The records indicate the patient was injured on the job and has undergone intensive primary and secondary levels of care. To date, no tertiary level of care has been performed on this patient. There is a recommendation from a neurosurgeon for this patient to undergo a work hardening program; however, the treating doctor determined that due to the patient's high pain level, he may be unable to satisfactorily complete a work hardening program.

Instead, the treating doctor recommended that the chronic pain management program would be appropriate for his condition. The National Treatment Guidelines allow for a chronic pain management program in conditions of this nature.

This patient has completed primary and secondary levels of care and continues to exhibit physical and psychological conditions that may adequately respond to a chronic pain management program. There is sufficient documentation provided in the records, as well as detailed behavioral assessment, that clearly indicates this patient is a candidate for a chronic pain management program. There is nothing in the records that would prevent him from enrolling and participating in this program. In conclusion, the request for chronic pain program x15 sessions is, in fact, reasonable, usual, customary, and medically necessary for the treatment of this patient's condition.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ 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 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(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 U.S. Postal Service from the office of the IRO on January 28, 2004

Sincerely,