

February 11, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0715-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 57 year-old male who sustained a work related injury on ___. The patient reported that he injured his back when he was carrying a panel with a co-worker. The patient reported that the co-worker dropped his end of the panel, causing the patient to experience immediate pain in his back. The patient indicated that he was initially treated with three months of physical therapy that consisted of massage, electrical stimulation and hot packs. A MRI was performed on 12/24/02 that indicated minimal disc bulging at the L2-L3 and L3-L4 levels and dehydration changes seen in the L2-L3 through L5-S1 intervertebral discs. On 3/27/03 the patient underwent a bone scan that was reported to be normal. The patient underwent a nerve conduction study on 4/1/03 that was reported to be normal. The patient was further treated with medications, physical therapy and a work hardening program. A copy of a prescription dated 8/6/03 indicated the patient was to discontinue physical therapy and was referred to pain management for two weeks for the diagnosis of lumbar strain.

Requested Services

Chronic Pain Management Program 5 times a week for 4 weeks.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 57 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer indicated that the patient had been treated with a three month course of physical therapy.

However, the ___ physician reviewer noted that the patient continued to complain of low back pain despite medical therapy, continued physical therapy and completion of a work hardening program. The ___ physician reviewer also noted that the patient was referred to a pain management specialist and was recommended to attend chronic pain management program. The ___ physician reviewer explained that the patient's chronic pain condition is directly related to the work related injury dated ___. The ___ physician reviewer indicated that the patient has been fully evaluated and has been diagnosed with chronic pain behavior with deconditioning, lower back pain with left leg radiculopathy, lumbar myofascial pain, and possibility of left lumbar facet arthropathy. The ___ physician reviewer explained that the patient also has documented mild symptoms of depression and anxiety secondary to his physical problems and concerns. The ___ physician reviewer also explained that the patient requires rehabilitation through daily physical and psychological interventions along with medical management to provide a more positive and long term outcome. The ___ physician reviewer further explained that the patient would be an optimal candidate for a interdisciplinary pain management program. Therefore, the ___ physician consultant concluded that the requested chronic pain management program 5 times a week for 4 weeks is medically necessary to treat this patient at this time.

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

This decision is deemed received by you 5 (five) 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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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. (Commission Rule 133.308(t)(2)).

Sincerely,

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 10th day of February 2004.