February 20, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0718-01

___ 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 25 year-old male who sustained a work related injury on ___. The patient reported that while at work he strained the right side of his low back. An initial comprehensive evaluation dated 4/25/03 indicated the AP & Lateral lumbar x-rays showed decreased disc space at L4-L5 and L5-S1, hypolordotic lumbar spine most likely due to muscle spasms, and mid left lateral list with a high left Iliac Crest 3cm. This note also indicated that the diagnoses for this patient included lumbar disc syndrome, lumbosacral sprain/strain, lumbar radiculitis, and myofascitis. This note further indicated that the treatment plan for this patient would include active rehabilitation, conservative spinal manipulation, active therapeutic exercises, stretching exercises, and strengthening exercises for the upper thoracic/lumobopelvic spine. The patient underwent electrodiagnostic studies on 5/2/03 that was reported as normal. A MRI of the lumbar spine dated 6/3/03 indicated moderated to large 5mm posterior central disc protrusion at T11-T12, and mild disc desiccation and small annular tears at T11-T12. On 11/12/03, the patient was evaluated by pain management and recommended for a chronic multidisciplinary pain management program due to depression, significant adjustment disorder, and exhibited anxiety.

Requested Services
Chronic Pain Management Program times 30 sessions.

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

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 25 year-old male who sustained a work related injury to his low back on ___. The ___ physician reviewer indicated that the diagnoses for this patient have included lumbar disc syndrome, lumbosacral sprain/strain, lumbar radiculitis and myofasciitis. The ___ physician reviewer noted that treatment for this patient's condition has included physical therapy and medical therapy. The ___ physician reviewer also noted that the patient underwent evaluation by a pain management specialist who recommended a chronic pain management program for the diagnoses of depression, anxiety and an adjustment disorder. The ___ physician reviewer explained that the documentation provided indicated the patient was referred for chronic pain management because he refused interventional treatments beyond medical therapy for treatment of his continued back pain. The ___ physician reviewer also explained that the patient had refused epidural steroid injections and only been treated with opiods for pain control. The ___ physician reviewer further explained that the MRI results indicated the patient required further evaluation by an orthopedic surgeon or a neurosurgeon to determine whether surgery could alleviate his pain. The ___ physician reviewer indicated that further treatment of this patient's diagnoses of depression and anxiety may be required. However, the ___ physician reviewer explained that the documentation provided did not demonstrate that the patient has tried and failed interventional therapy or alternative medical regimens. Therefore, the ___ physician consultant concluded that the requested chronic pain management program times 30 sessions is not medically necessary to treat this patient's condition 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 20th day of February 2004.