

January 28, 2004

Amended February 3, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-04-0722-01
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 care rendered 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

The patient was injured on the job when he picked up a bundle of rebar and felt an immediate onset of low back pain. The injury occurred on ___. He initially was treated with PT to include hot packs and muscle stimulation. CT of the lumbar spine indicated spondylolisthesis and degenerative joint disease of the lumbar spine. He was treated with chiropractic therapy by ___, which did give some temporary relief of the pain. The patient has described his pain as ongoing and intense on a daily basis. He eventually underwent a laminectomy with instrumentation at L5-S1 and a bone growth stimulator by ___ on August 23, 2000. The surgical procedure addressed the spondylolisthesis. The bone growth stimulator became painful and it was removed on May 4, 2001. There was a recommendation by ___ that the patient have an EMG and removal of the hardware on July 2, 2003, but no records indicate whether this was actually done. After extensive rehabilitation, the patient was prescribed a chronic pain program for 20 visits.

Records indicate that the patient is having difficulty coping with the pain in the lumbar spine after a total of 2 surgeries. The records clearly indicate that the patient is diagnosed as having a depressive reaction to his medical condition.

DISPUTED SERVICES

The carrier has denied the medical necessity of a chronic pain management program for 20 sessions.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The patient does clearly qualify for a chronic pain management program. The patient has been injured for four years and has undergone multiple procedures, which were invasive in nature and had a debilitating impact on this patient's ability to perform his job. The patient's records indicate that he is indeed a motivated employee who has attempted to return to work but in failing to do so he has become more and more depressed and unable to function in his normal activities of daily living. The patient also is now apparently dependent upon pharmacology, not unexpected considering his history. There was clear demonstration that this patient qualifies for the program due to his presence of chronic pain, his likelihood of benefiting from the program and psychosocial issues, which need to be treated for this patient to return to work. As a result, this patient is clearly a candidate for this program and it is found to be medically necessary.

___ 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 this finding by US Postal Service to 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 3rd day of February 2004.