

February 17, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
7551 Metro Center Drive, Suite 100  
Austin, TX 78744-1609

MDR Tracking #: M2-04-0757-01  
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 proposed care 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

This patient was injured on the job while performing repetitive motions of lifting heavy boxes. She suffered pain in the neck, upper back and left shoulder as a result of the overuse. She has been treated with numerous medications, including Vicodin, Skelaxin and Zoloft. She was also treated with ESI therapy as well as extensive chiropractic and physical medicine. MRI revealed a disc herniation at C6/7 and multiple bulges. The patient was recommended for a work hardening program as an FCE that was performed on the patient indicating a light duty and the patient's duty responsibility was that of a medium/heavy job. It is unclear as to how much of a work hardening program the patient attended, but there was apparently a chronic pain program instituted in July of 2003. Surgery was performed in August of 2003 in the form of a discectomy and fusion. The treating doctor has performed 10 days of chronic pain treatment on this patient which he states has reduced the patient's dependency on prescription medication and has improved her functional abilities. A peer review was performed by \_\_\_, which indicated that no further care was necessary in this case except on a follow-up by the surgeon on this case.

## REQUESTED SERVICE

The carrier has denied the medical necessity of 20 days of chronic pain management.

## DECISION

The reviewer agrees with the prior adverse determination.

## BASIS FOR THE DECISION

The requestor on this case failed to demonstrate exactly why a chronic pain program would help this patient by going for 20 more days. Clearly, there was some result from the first 10 days but this does not mean that an additional 20 days would automatically be necessary. There was no support presented to indicate that this program would benefit the patient's stated desire to return to a workplace. I feel that the care that was rendered on this case was much more than adequate. Chronic pain management has, from the documentation received, been exhausted and should not be considered necessary from the files presented in this case.

\_\_\_ 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 by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and 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 17<sup>th</sup> day of February 2004.**