

NOTICE OF INDEPENDENT REVIEW DECISION

March 25, 2004

MDR Tracking #: M2-04-0899-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in psychiatry which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This patient sustained an injury on ___ while unloading sacks of concrete. An MRI dated 09/03/03 revealed disc protrusions at L4-5 and L5-S1 compressing on the thecal sac. Treatment has included physical therapy, injections, chiropractic treatments, TENS unit, and various oral medications. He has had a psychiatric evaluation and is recommended for a chronic pain management program.

Requested Service(s)

A 30-day chronic pain management program

Decision

It is determined that the proposed 30 day chronic pain management program is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Despite multiple outpatient treatments including physical therapy, injections, massage, oral medications, chiropractic care and TENS unit, the patient continues to have severe pain and depression. It is perfectly appropriate to treat him with antidepressant medication and an intensive multidisciplinary chronic pain

program to help focus on his psychiatric, psychological, emotional, and physical needs. This is especially important due to his history of alcohol use and his potential to continue being depressed with increased alcohol use. There is a much greater chance of recovery if he participates in the chronic pain management program. Therefore, it is determined that the proposed 30 day chronic pain management program is medically necessary.

This decision by the IRO 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) 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 hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, 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 all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), 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 25 th day of May 2004.
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