

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO: 453-04-5350.M2

April 6, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0942-01

___ 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 54 year-old male who sustained a work related injury on ___. The patient reported that while at work he was carrying a box of chickens into a cooler when he slipped on some ice and fell back, hitting his head and back on the floor. The patient was transported to the emergency room where he underwent x-rays of the cervical spine, lower spine, and thoracic spine. The patient has also undergone MRI studies of the lumbar spine, thoracic spine, and head, x-ray of the pelvis, and x-ray of the chest. The initial diagnosis for this patient was a stable compression fracture at the L5 level. The patient has been treated with physical therapy, trigger point injections, and thoracic epidural steroid injections. On 5/20/03 the patient underwent a T12 percutaneous vertebroplasty. The current diagnoses for this patient include lumbosacral sprain/strain and postlaminectomy syndrome.

Requested Services

Chronic behavioral pain management program times 30 sessions

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 54 year-old male who sustained a work related injury to his back and head on ____. The ___ physician reviewer indicated that the patient underwent a complete evaluation including MRI studies of the lumbar spine, thoracic spine and head.

The ___ physician reviewer also indicated that the patient was noted to have a T12 compression fracture and had been treated with physical therapy, trigger point injections and thoracic epidural injections. The ___ physician reviewer noted that the patient continued with complaints of back pain and underwent a T12 percutaneous vertebroplasty on 5/20/03 followed by physical therapy and continued medical treatment. The ___ physician reviewer also noted that postoperatively the patient continued to complain of back pain related to muscle spasm and has now been referred to a comprehensive pain management program. The ___ physician reviewer explained that the patient has completed a significant trial of conservative therapy, is 7 months post surgical intervention, but continues with significant back pain related to spasms. The ___ physician indicated that the patient is not a candidate for further interventional therapy. The ___ physician reviewer explained that the requested program would help establish pain coping techniques with counseling and education to maximize sustained pain relief. Therefore, the ___ physician consultant concluded that the chronic behavioral pain management program times 30 sessions is 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 6th day of April 2004.