

May 3, 2004

David Martinez  
TWCC Medical Dispute Resolution  
MS-48  
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Austin, TX 78744-1609

MDR Tracking #: M2-04-0966-01  
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 Medical Doctor board certified and specialized in Physical Medicine and Rehabilitation. 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 a 31-year-old laborer at the time of his work accident on \_\_\_ in \_\_\_ in which he injured his lumbar spine. He felt the onset of low back pain, bilateral leg pain syndrome. His MRI done later revealed evidence of a prominent disc protrusion, impinging at L5/S1. He did not have sufficient response to conservative therapy. On 04/02/03 he underwent surgery, a L5/S1 bilateral laminectomy, complete discectomy, and posterior lumbar interbody fusion with graft from the iliac crest performed by \_\_\_. He has continued requiring pain management treatment and has had some extensive care. On September 03, \_\_\_ and a psychologist evaluated him with a psychological assessment. He reportedly went through a work hardening program. He has continued receiving multiple medications, including those from \_\_\_, an internist. This patient has continued to be greatly impaired by his lumbar injury and ongoing pain problem.

#### REQUESTED SERVICE

A 30-session chronic behavioral pain management program is requested for this patient.

#### DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The \_\_\_ reviewer agrees with the conclusions in the letter recommending treatment, as written by \_\_\_ on 02/09/04. The reviewer disagrees with the reconsideration statement of 02/12/04 and the rationale for stating the chronic pain management is not clinically indicated. This post program very likely would not render the patient “completely well,” but would have a high chance of giving this gentleman at least significant benefit, particularly in the round of better insight of pain coping mechanisms and how to et on with his life in the presence of this medical problem.

The reviewer disagrees with the statement from the attorney, \_\_\_, who recommends denial because of “beyond mere declarations, there is no objective documentation this patient needs or would benefit from either the vocational or the psychosocial elements of such a program.” It would be very difficult to provide such “objective documentation” before the program took place. The same argument could have been given concerning the multiple spinal injections, or even his back surgery, before they were done. (It is not even clear now how much benefit, if any, the patient received from those procedures.)

Review of this particular case appears to give sufficient evidence for justification of the multidisciplinary outpatient program. This patient has limited education, fairly manual labor had been his only source of income, he speaks limited English, is under severe financial strain/pressure, and any benefit/referral success he would receive from TRC (Texas Rehabilitation Commission) vocational retraining possibilities would be aided by what the patient can learn/gain from the proposed multidisciplinary program.

The 30-session chronic behavioral pain management program is justified for this patient.

\_\_\_ 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 3<sup>rd</sup> day of May 2004.**