

April 21, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-1062-01

___ 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 attempting to pull a patient onto a stretcher when he injured his low back. A initial evaluation note dated 8/1/02 from the treating doctor indicated that the patient was initially treated with medications and approximately two weeks of physical therapy. It also indicated that the patient was scheduled for back surgery consisting of lumbar fusion. It further indicated that MRI films dated 8/30/01 showed dessication of the discs at T10-T11, L3, L4, and L5, posterior annular bulging of all levels indicated, and possible herniation at the L4-L5 level. The patient was continued on a physical therapy program consisting of heat, soft tissue mobilization, ultrasound, hot/cold pack, neuromuscular stimulation, and a lumbar support belt. 11/19/02 the patient underwent a MRI of the thoracic spine that indicated small central disc herniation at T6-7. On 12/2/02 the patient was evaluated by a pain management specialist and underwent an EMG/NCV of the lower extremities that indicated facet joint arthropathy at L3-L4 and L4-L5. The patient was then further treated with a series of epidural injections and nerve root block at left T10 and continued therapy. The patient has also undergone individual counseling sessions with biofeedback. A progress note dated 1/23/04 indicated that the patient has continued lower back pain, interferences in his sleep pattern, and depression related to the work related injury. It noted that the patient would be referred for a chronic behavioral pain management program.

Requested Services

Chronic 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 low back on ____. The ___ physician reviewer indicated that the initial evaluation was back strain and that the patient was treated with pain medications and physical therapy. The ___ physician reviewer noted that the patient had undergone an MRI that demonstrated disc disease at T10, T11, L3, L4, and L5, posterior annular bulging of all levels indicated, and possible herniation at the L4-L5 level. The ___ physician reviewer also noted that the patient had been treated with conservative therapy consisting of medications, physical therapy, ultrasound, neuromuscular stimulation, and a lumbar support belt. The ___ physician reviewer further noted that the patient had been treated with interventional therapy consisting of a series of epidural steroid injections and a nerve block at left T10. The ___ physician reviewer explained that the patient continues with complaints of low back pain and in association has developed a sleep disturbance with depression requiring medical therapy. The ___ physician reviewer noted that the patient had undergone counseling sessions with biofeedback and is presently considered an optimal candidate for a chronic pain management program.

The ___ physician reviewer explained that this patient has a chronic pain condition directly related to the work related injury sustained on ____. The ___ physician reviewer indicated that the patient has undergone courses of conservative and interventional therapy and continues with low back pain and has developed depression requiring counseling and medical management. The ___ physician reviewer also indicated that the patient has evidence of facet joint arthropathy at L3-4 and L4-5 and is not considered a candidate for any surgical intervention. The ___ physician reviewer explained that the patient's pain syndrome would benefit from a multidisciplinary approach to pain management. The ___ physician reviewer also explained that the pain management program would provide a balanced program of patient care as well as a diverse collection of medical specialists and office support personnel. The ___ physician reviewer further explained that the multidisciplinary model provides extensive diagnostic, therapeutic, and rehabilitative services to maximize the potential for sustained pain control. Therefore, the ___ physician consultant concluded that the requested Chronic 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 21st day of April 2004.