

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING  
IS THE RELATED SOAH DECISION NO.:**

**SOAH DOCKET NO. 453-04-6352.M2**

**NOTICE OF INDEPENDENT REVIEW DECISION**

April 27, 2004

RE: MDR Tracking #: M2-04-1087-01  
IRO Certificate #: 4326

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 by the American Board of Family Practice in 1980 and who provides health care to injured workers. This 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. The documentation utilized by the physician reviewer for the decision determination is attached.

Clinical History

This 26 year old male sustained a work related injury on \_\_\_ when his vehicle struck another vehicle causing back, neck, chest and knee pain. He underwent an MRI of the lumbar spine on 09/27/02, an MRI of the cervical spine on 10/31/02, and a discogram on 05/12/03. On 08/23/03, the patient underwent an instrumented posterolateral lumbar fusion of L4-5 and L5-S1. The patient continues to complaint of pain and the treating physician is requesting that the patient undergo a chronic pain management program for 40 days.

Requested Service(s)

Chronic Pain Management Program for 40 days

Decision

It is determined that the Chronic Pain Management Program for 40 days was medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This 26 year old male who sustained a work related injury on \_\_\_ had a postlateral lumbar fusion of the L4-5 and L5-S1. The patient went through the work hardening program with improvement; however, he still requires additional treatment. Therefore, the chronic pain management program for 40 days are 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 27<sup>th</sup> day of April, 2004.