

May 6, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1190-01

___ 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 53 year-old female who sustained a work related injury on ___. The patient reported that while at work she tripped and fell injuring both her knees, right shoulder and lumbar back. The patient underwent a right shoulder surgery on 4/15/02 followed by a course of physical therapy. The patient had complaints of continued shoulder and low back pain. She was evaluated by her current treating doctor and was continued on a course of physical therapy. An MRI of the lumbar spine dated 6/20/03 showed mild disc narrowing, loss of normal signal, posterior central, paracentral broad based protruded herniated disc with thecal sac impingement, associated osteophytic spurring, facet hypertrophy, severe spinal stenosis, proximal neural canal narrowing and mild anterolisthesis at L4-L5, associated degenerative facet changes note, and mild posterior disc bulge at L3-L4. The diagnoses for this patient have included postsurgical right shoulder, lumbar herniated nucleus pulposus, lumbar nerve root irritation, and muscle spasms. The patient has been treated with physical therapy, oral medications, and right shoulder surgery. The patient is being referred to a chronic behavioral pain management program for continued complaints of shoulder pain and low back pain.

Requested Services

Chronic Behavioral Pain Management five times a week times six weeks, 30 sessions.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a female who sustained a work related injury to her right shoulder, low back and bilateral knees on ___. The ___ physician reviewer indicated that the patient underwent right shoulder surgery followed by a course of physical therapy but continued to complain of shoulder and low back pain. The ___ physician reviewer noted that the patient had been evaluated by orthopedics and underwent an MRI of the lumbar spine that demonstrated mild disc narrowing, posterior central, paracentral broad based disc protrusion with thecal sac impingement, associated osteophytic spurring, facet hypertrophy, severe spinal stenosis, degenerative joint disease, proximal neural canal narrowing and mild anterolisthesis at L4-5 and mild anterior disc bulge at L3-4. The ___ physician reviewer also noted that the diagnoses for this patient have included post surgical right shoulder, lumbar herniated disc, lumbar root irritation, and muscle spasms. The ___ physician reviewer further noted that the treatment for this patient's condition has included physical therapy and medications. The ___ physician reviewer indicated that the patient has continued back pain with evidence of radiculopathy and has been followed by orthopedics. The ___ physician reviewer noted that an MRI of the lumbar spine obtained 6/20/03 showed disc disease with impingement and spinal stenosis. The ___ physician reviewer explained that the patient has documented anxiety, continued shoulder pain, and low back pain with positive straight leg raising on exam. The ___ physician reviewer also explained that this patient's condition has deteriorated and surgery may be a viable option. The ___ physician reviewer further explained that a chronic pain management program would be indicated once all conservative and interventional treatment regimens for pain control have been tried and failed. Therefore, the ___ physician consultant concluded that the requested Chronic Behavioral Pain Management five times a week times six weeks, 30 sessions is not 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 May 2004.