

June 25, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

### MDR Tracking #: M2-04-1369-01

\_\_\_ 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 and is familiar with the condition and treatment options at issue in this appeal. 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 58 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he injured his back. The diagnoses for this patient have included HNP lumbar area and chronic pain. Treatment for this patient's condition has included physical therapy, exercises, massage, electrical stimulation and epidural steroid injections. The patient has also participated in a pain management program. The patient is being referred for a chronic pain program 15 sessions.

### Requested Services

Chronic Pain Program 15 Sessions

### Documents and/or information used by the reviewer to reach a decision:

#### *Documents Submitted by Requestor:*

1. Chronic Pain Assessment 9/13/01
2. Chronic Pain Progress Reports 10/11/01 – 11/20/01

*Documents Submitted by Respondent:*

1. Position Statement 5/11/04
2. Chronic Pain Assessment 9/13/01

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 58 year-old male who sustained a work related injury to his back on \_\_\_\_. The \_\_\_ physician reviewer indicated that the diagnoses for this patient have included lumbar herniated disc and chronic back pain. The \_\_\_ physician reviewer noted that the treatment for this patient's condition has included medical therapy, physical therapy, exercises, massage therapy, electrical stimulation and epidural steroid injections. The \_\_\_ physician reviewer also noted that the patient had participated in a pain management program and has been referred for further pain management sessions. The \_\_\_ physician reviewer explained that the patient had undergone conservative and interventional treatment but continues with chronic back pain. The \_\_\_ physician reviewer noted that the patient is not considered a surgical candidate. The \_\_\_ physician reviewer indicated that the patient had previously attended a chronic pain management program but noted that the patient had to withdraw from the program due to cardiac problems. The \_\_\_ physician reviewer noted that the patient had made progress in this pain management program before withdrawing. The \_\_\_ physician reviewer explained that the patient would benefit from participation in an interdisciplinary pain management program. The \_\_\_ physician reviewer also explained that the goals of the chronic pain management program would include reduction in pain intensity, enhancement of physical functioning, proper use of medication and treatment of his depression and anxiety. Therefore, the \_\_\_ physician consultant concluded that the requested Chronic Pain Program 15 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 25<sup>th</sup> day of June 2004.