

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 15, 2004

RE: MDR Tracking #: M2-04-1380-01
IRO Certificate #: 5242

___ 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 Psychiatric reviewer (who is board certified in Psychiatry) who has an ADL certification. 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.

Submitted by Requester:

- Letter dated 6/1/04 by ___
- Appeal letter dated 4/23/04 by ___
- Note dated 4/22/04 by ___
- Chemical dependency evaluation dated 4/23/04 by ___
- Initial request for pre-authorization for a chronic pain management program dated 4/20/04
- Psychological evaluation dated 3/8/04
- Evaluation notes by ___ dated 3/8/04 and 5/13/04
- Physical rehabilitation evaluation dated 3/8/04
- X-rays of the cervical spine, thoracic spine and lumbar spine dated 10/21/03
- Evaluation by ___ dated 11/28/03
- An MRI of the lumbar spine dated 11/19/03
- An MRI of the cervical spine dated 11/5/03

Submitted by Respondent:

- Initial review determination dated 5/14/04 for a request for bilateral cervical facet blocks

Clinical History

The claimant reportedly injured his back in the course of his work on _____. Subsequent to that injury he has had physical therapy, medications, chiropractic treatment, steroid injections, counseling and work hardening. None of these interventions have made a significant impact on his pain. A request was made for a chronic pain management program that apparently was denied due to a concern about alcohol dependency. The claimant subsequently underwent a chemical dependency assessment. The evaluation indicated that chemical dependency was not an issue with respect to treatment for his back pain. Subsequently the chronic pain management program was denied apparently because of the differences between objective testing and the claimant's pain complaints. The specific letters of denial are not included in the documentation nor are the dates of denial. It appears that subsequent to the denial for a chronic pain management program _____ made a request for additional trigger point injections. These were denied apparently because there was not a prior benefit from trigger point injections nor was there evidence of cervical facet disease on neuroimaging study.

Requested Service(s)

Ten days (80 hours) of a chronic pain management program for the claimant.

Decision

I agree with the insurance carrier that the chronic pain management program, at the time of denial, was not medically necessary.

Rationale/Basis for Decision

It appears that there was not coordination of care among the primary treating doctors of this claimant, as additional secondary levels of treatment were being requested at the same time that a tertiary level program was being requested. The tertiary level program is appropriate once all primary and secondary level interventions have been exhausted. Since the facet blocks were requested, it appears that secondary levels of intervention are still a consideration for this claimant. However, these injections were subsequently denied, and if no further secondary interventions are indicated, it would appear that the claimant probably would be a candidate for the chronic pain management program.

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 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.

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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 22nd day of June 2004