

NOTICE OF INDEPENDENT REVIEW DECISION

Date: July 29, 2004

MDR Tracking #: M2-04-1429-01

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:

- Dispute resolution request forms
- Letter dated 6/7/04 from attorney, ___
- Telephone documentation log
- Reviews from ___ dated 10/30/03, 4/6/04, 4/7/04, 4/14/04, 4/15/04, 4/22/04 and 4/27/04
- Medical dispute letter from ___ dated 4/23/04
- Behavioral assessment from ___ dated 3/29/04
- Treatment plan and goals from ___ dated 3/29/04
- Appeal letter from ___ dated 4/7/04
- MRI report dated 4/25/03

Submitted by Respondent:

- Letter dated 7/7/04 from attorney, ___
- Letter dated 6/7/04 from attorney, ___
- Report of medical evaluation by ___ dated 4/19/03
- Review of medical history and physical exam by ___ dated 4/18/03
- Assessment by _____ dated 8/7/03
- Reviews from _____ dated 10/30/03, 4/6/04, 4/7/04, 4/14/04, 4/15/04, 4/22/04 and 4/27/04
- Dispute resolution request forms

Clinical History

On ___ the claimant fell from a ladder while performing his duties as a water plant operator, landing on his buttocks. During the fall, his foot was caught in the ladder. He has not worked since then. (Documents provided imply this is secondary to chronic knee pain.) Review of medical history indicates bone scan and MRI) 5/25/04 and 5/31/04; 7/27/00) of the knee revealed a microfracture, swelling and bruising of the bone. Operative report (7/27/00) confirmed these findings. Cervical x-rays (7/31/00) indicate muscle spasm. EMG studies (8/16/00) were negative. MRI of the hips (4/11/01) was negative. Follow up MRI of the knee (4/11/01) showed only mild swelling. Information regarding medical or psychiatric treatment received between these dates and the current request was not available. MRI of the lumbar spine dated 4/25/03 demonstrated disc herniations at L5/S1, L2/3 and L4/5.

Requested Service(s)

Ten sessions of a chronic pain management program

Decision

I disagree with the insurance carrier and find that the services in dispute are medically necessary.

Rationale/Basis for Decision

Information regarding treatment to date is limited. There is no evidence of psychiatric services being performed. Information regarding somatic treatment seems to be limited to assessments and to the single knee surgery. I could find no information regarding whether or not the herniated discs in the lumbar region had been addressed. This creates confusion as to whether the nature of the claimant's pain is somewhat generated or is psychosomatic. It would be worthwhile to evaluate how he would do in a brief therapeutic environment to teach him skills regarding the psychological factors that perpetuate his pain related/dependent behaviors that are keeping him from working. It could also be helpful to teach him physical exercises to strengthen his back, especially in light of a possible disc injury. The record indicates the claimant is overweight. Although this is unlikely to be secondary to the work related injury, it is likely to be exacerbating pain. Nutritional counseling would be beneficial. Whereas it would more commonly be recommended that he receive outpatient office based treatment first, the notes from ___ indicate that these services can all be accessed there. Rather than have the claimant seek out some of these services and then later refer him for more intensive treatment, it might be more fiscally prudent to treat him in a chronic pain management program for a few sessions and then provide infrequent outpatient follow up as necessary. There is literature that would support a higher likelihood of success using a multidisciplinary combination of psychological and physical medicine treatment program, rather than addressing each component separately. There should be documentation of significant benefit from these 10 sessions to support continuation of the program. Assuming good benefit, the total program length should not exceed 20 sessions. (Clinical practice guidelines for chronic non-malignant pain syndrome patients II: an evidence-based approach. J Back Musculoskeletal Rehabil 1999 Jan 1; 13:47-58 (65 references))

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.