

July 8, 2004

Re: Medical Dispute Resolution
MDR #: M2-04-1467-01
IRO Certificate #: 5055

Dear ____

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: correspondence, office notes, operative and radiology reports.

Information provided by Respondent: correspondence and designated doctor exams.

Clinical History:

This patient is a 54-year-old male who was injured on the job on _____. He has been treated since that time and is now status post 3 lumbar surgeries including hardware removal. The records provided for review indicate that he has a moderate level of depression and moderate-to-high level of anxiety, as measured by his BDI (23) and BAI (39) scores. The patient is on excessive medications that include hydrocodone, Neurotin, Zanaflex, Vioxx and Ambien, to cope with continued pain.

Disputed Services:

Chronic behavioral pain management 5 X weekly X 2 weeks (10 sessions).

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the

opinion that the pain management program in dispute as stated above is medically necessary in this case.

Rationale:

Based on the records reviewed, the patient does meet the standard criteria for a chronic pain management program. It is medically reasonable and necessary to request the first 10 sessions to see how the patient responds to the chronic pain management program. That is the usual accepted criteria for this type of program.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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.

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 July 8, 2004.