

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-0117.M2

August 3, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1469-01

___ 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 53 year-old male who sustained a work related injury on ___. The patient reported that while at work the patient fell injuring his back. On 3/7/03 the patient underwent a MRI of the lumbar spine. On 3/28/03 the patient underwent an EMG study that was reported to be normal. The diagnoses for this patient have included lumbar radiculopathy, herniated nucleus pulposus at L4-L5, lumbar stenosis at L2-L3 and L3-L4, and lumbago. Treatment for this patient's condition has included physical therapy and facet joint injections. The patient is being referred to a chronic pain management program for further treatment of his condition.

Requested Services

Chronic Behavioral Management 5 times a weeks times 2 weeks.

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

Documents Submitted by Requestor:

1. MRI report 3/7/03
2. Physician Letter 10/17/03
3. Review of Medical History and Physical Exam 10/23/03

4. Office notes 11/24/03 – 1/8/04
5. Therapy Progress Note 1/21/04 – 2/19/04

Documents Submitted by Respondent:

1. Daily Progress and Procedural Notes 3/5/04 – 5/17/04
2. Same as above

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 53 year-old male who sustained a work related injury to his low back ____. The ___ physician reviewer indicated that the diagnoses for this patient included lumbar radiculopathy, degenerative disc disease, and lumbago. The ___ physician reviewer noted that treatment for this patient's condition has included medical therapy, physical therapy, chiropractic adjustments, and facet joint injects. The ___ physician reviewer also noted that the patient continues with complaints of back pain and that he has been recommended to attend a chronic pain management program. The ___ physician reviewer explained that the documentation demonstrates that the patient has a work related chronic pain condition and that he has exhausted conservative therapies. The ___ physician reviewer also explained that the patient had undergone a psychological evaluation that indicated his chronic pain condition has a psychological component. The ___ physician reviewer further explained that the patient could benefit from a pain management program that would improve functional capabilities, advise on specific medical management, and provide psychological, social, and vocational assessments. Therefore, the ___ physician consultant concluded that the requested Chronic Behavioral Management 5 times a weeks times 2 weeks 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 3rd day of August 2004.