

July 29, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

MDR Tracking #: M2-04-1477-01

___ 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 male who sustained a work related injury on ___. The patient reported that while at work he injured his low back. X-rays of the lumbar spine performed on 1/19/01 indicated mild degenerative spondylosis involving L4-5 and L5-S1, greater than L2-3. The patient also underwent a MRI of the lumbar spine on 2/22/02. On 8/28/02 the patient underwent a T10-T11 laminectomy for the diagnoses of thoracic myelopathy secondary to T10-T11 spondylosis and spinal stenosis. Postoperatively the patient has been treated with rehabilitative therapy. The patient has continued complaints of pain and has been recommended for a chronic behavioral pain management program 5 times a weeks for 6 weeks.

Requested Services

Chronic Behavioral Pain Management 5 times a week times 6 weeks (30 sessions).

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

Documents Submitted by Requestor:

1. X-ray report lumbar spine 1/22/01
2. MRI report 2/22/02
3. Initial Medical Report 5/20/02
4. Neurology office notes 6/13/02 – 2/14/03
5. Operative Note 8/28/02

6. EMG report 2/6/03
7. MRI report 2/21/03

Documents Submitted by Respondent:

1. No medical documents submitted

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 on ____. The ___ physician reviewer indicated that the diagnoses for this patient have included thoracic myelopathy secondary to T10-T11 spondylosis and spinal stenosis. The ___ physician reviewer noted that initially the patient had been treated with conservative care but that subsequently underwent a T10-T11 laminectomy. The ___ physician reviewer also noted that the patient had continued complaints of pain requiring oral medications. The ___ physician reviewer indicated that the patient completed a two-week pain management program and has been recommended to complete an additional 6 weeks (30 sessions). The ___ physician reviewer explained that the documentation provided clearly demonstrates that this patient suffers from a work related chronic pain condition and has tried and failed conservative and interventional treatment. The ___ physician reviewer also explained that the patient has EMG documented neuropathy and required medical therapy for pain control. The ___ physician reviewer indicated that the patient's initial treatment in the pain management program identified depression and anxiety associated with his chronic pain condition. The ___ physician reviewer explained that additional pain management session will serve to enhance functional improvement, allow for decrease in medication, increase physical capabilities, and provide additional psychological counseling and support. The ___ physician reviewer also explained that the initial two weeks of treatment were reported to have had a positive effect on this patient's condition. Therefore, the ___ physician consultant concluded that the requested Chronic Behavioral Pain Management 5 times a week times 6 weeks (30 sessions) are 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 29th day of July 2004.