

July 19, 2004

MDR Tracking #: M2-04-1525-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Physical Medicine and Rehabilitation. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

This patient was injured at work on \_\_\_ and developed severe left side and low back pain. He was treated with rest and medications without improvement. Subsequently he underwent several unsuccessful surgeries of his cervical spine, lumbar spine, left shoulder and left elbow. He completed a work hardening program but is still not working. He is presently seeing a pain management specialist for severe, unremitting neck, left shoulder and low back pain. He takes Celebrex, Zanaflex and Vicodin on a daily basis. He has been evaluated by the Valley Integrated Pain Assessment and Care Clinic for a multidisciplinary pain management program.

#### REQUESTED SERVICE

Thirty sessions of multidisciplinary outpatient chronic pain management services are requested for this patient.

#### DECISION

The reviewer disagrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The patient has been evaluated by a psychiatrist at \_\_\_ and a diagnosis of chronic pain disorder has been documented with supporting clinical history and mental status examination. The goals of the program for this patient have been clearly stated in \_\_\_'s evaluation report and appear compatible with the TWCC Spine Treatment Guidelines. Furthermore, there is evidence from a

systematic review of the medial literature that concludes that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration for persons with chronic back pain reduces pain and improves function compared with inpatient or outpatient non-multidisciplinary treatments or usual care (1).

In conclusion, it appears that the patient is a reasonable and appropriate candidate for an intensive multidisciplinary pain management program and that such a program meets the criteria of medical necessity.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

(1) Van Tulder M and Koes B. Low back pain and sciatica (chronic). Clinical Evidence Concise. London: BMJ Publishing Group, December 2003, (10), pp259-261.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to 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.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 19<sup>th</sup> day of July, 2004.**