

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-1561-01
IRO Certificate Number: 5259

July 29, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY

This is a 43 year old gentleman with a ___ year injury to the lumbar spine. The MRI from September 2001 noted degenerative disc disease and minimal multiple level disc bulging. It is not clear but apparently this gentleman underwent two lumbar surgeries. There were no operative notes presented, but this is reflected in one of the RME assessments. The June 14, 2004 progress notes from ___ notes multiple treatments but no mention of a surgical intervention. ___ had referred the claimant for a pain management assessment. However,

the notes also reflect, as does the May 5, 2004 psychological evaluation that the claimant underwent a similar chronic pain program only two years prior. The most current imaging studies presented noted only minimal degenerative changes in the lumbar spine

REQUESTED SERVICE(S)

30 day chronic pain management program.

DECISION

Denied. This program is not reasonable and necessary care and has already been completed.

RATIONALE/BASIS FOR DECISION

The reported mechanism of injury was a blunt trauma to the cervical spine more than six years ago. This expanded to include the lumbar spine. There was a limited amount of pathology noted. However, a cervical surgery was undertaken and this was followed up with a procedure to remove the hardware and address the on-going complaints of pain. Chronic pain management programs are not pain abatement programs. People are to be taught how to cope with the chronic pain. The claimant has already been through such a protocol, only two years ago. The techniques and other modalities should be fresh enough so that they can still be applied. Moreover, as noted in the Journal of Back and Musculoskeletal Rehabilitation (Jan 1, 1999) the optimum for such a program is only 20 days. Thus this 30 program appears to be excessive. The national success rate for such programs is less than 33%. In that this has already failed once, there is no reasonable expectation of any future success. Accordingly, with all of the above in mind, there is no reason to repeat a 30 day CPMP.

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 (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 30th day of July 2004.