

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

**SOAH DOCKET NO. 453-05-1197.M2**

September 29, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M2-04-1924-01  
IRO Certificate #: 5348**

\_\_\_ 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 61 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he injured his back when he was installing a 35" picture tube for a television. The patient was initially evaluated in an emergency room and referred to a physician where he underwent an epidural steroid injection. The patient later presented to his primary care physician's office where he was instructed to take pain medication. The patient then presented to another physicians office where he underwent x-rays and was told that the discs in his back had collapsed resulting in pinched nerves requiring surgical intervention. Prior to surgery the patient was treated with further epidural steroid injections, physical therapy and work hardening. In 7/03 the patient underwent a fusion at the L4-5-6 levels. Postoperatively the patient had been treated with oral medications. The patient has been recommended for a chronic pain management program.

Requested Services

Chronic Pain Management Program times 30 sessions.

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

*Documents Submitted by Requestor:*

1. Request for services 7/8/04
2. Treatment Plan
3. Individual Psychotherapy notes 5/17/04 – 7/7/04
4. Progress Notes 3/29/04, 4/26/04 and 6/21/04
5. Initial Interview 4/20/04
6. IME 12/30/03
7. FCE 12/9/03, 3/11/03

*Documents Submitted by Respondent:*

1. Orthopedic Notes 8/29/02 – 5/4/04
2. MRI report 8/30/02
3. Operative Report 11/1/02
4. FCE 2/6/03, 3/11/03
5. Individual Psychotherapy Notes 5/17/04 – 6/29/04

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 61 year-old male who sustained a work related injury to his lower back on \_\_\_\_. The \_\_\_ physician reviewer indicated that the patient's initial treatment of his condition consisted of an epidural steroid injection followed by medical therapy, additional epidural steroid injections, physical therapy, a work hardening program and subsequently a spinal fusion at L4-5-6 levels in 7/03. The \_\_\_ physician reviewer noted that the patient is currently under the care of a pain management specialist and continues with significant pain despite medical therapy with Lortab and Topamax. The \_\_\_ physician reviewer also noted that the present diagnoses included failed back surgery syndrome, lumbosacral radiculopathy, myofascial pain syndrome, and depression. The \_\_\_ physician reviewer indicated that the patient has been recommended to attend a chronic pain management program for additional pain management therapy. The \_\_\_ physician reviewer explained that the documentation provided indicates that the patient has a work related chronic pain condition and has failed conservative and interventional therapy and in addition has depression. The \_\_\_ physician reviewer noted that the patient completed 8 individualized counseling sessions and the recommendation was that the patient begin a chronic pain management program to address pain management, coping skills, and the emotional distress caused by the work related injury. The \_\_\_ physician reviewer explained that the patient has physical and mental impairment greater than expected and that his condition requires a multidisciplinary approach in the structured and supervised patient setting that a chronic pain management program can provide. Therefore, the \_\_\_ physician consultant concluded that the requested chronic pain management program times 30 session 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 29th day of September 2004.