



Texas Medical Foundation

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NOTICE OF INDEPENDENT REVIEW DECISION

November 13, 2003

Requestor

Shanti Pain & Wellness Clinic
Attn: Daniela Group
8705 Katy Freeway, Ste 105
Houston, TX 77024

Respondent

Texas Mutual Insurance Co.
Attn: Ron Nesbitt
221 W. 6th., Ste 300
Austin, TX 78701

RE: Injured Worker:
MDR Tracking #: M2-04-0247-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in Pain Management which is the same specialty as the treating physician. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained injuries to her lower back and neck on _____ mechanism unknown. Cervical and lumbar MRIs dated 12/31/02 revealed C4 to C7 herniated discs, and L4-5 and L5-S1 herniated discs. She has attended physical therapy and had one lumbar facet injection which gave her 90% relief for one day only. The patient was referred to a pain management physician and started into a chronic pain program.

Requested Service(s)

A chronic pain management program three-to-six times per week for 20 sessions

Decision

It is determined that the proposed chronic pain management program three-to-six times per week for 20 sessions is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had pain since an injury in She has developed psychological traits of chronic pain syndrome. She has undergone extensive treatment including medications, time, and facet blocks without success. Psychological evaluation shows traits such as poor coping, sleep disturbance, anxiety, depression, decreased activity, and high sense of disability due to pain. Evidence-based approaches to this kind of chronic pain patient show best response from treatment with a 20 day multidisciplinary pain program as recommended.

With the program, the records show improvement. From a note dated 08/20/03, "patient more motivated and compliant, sleep improved, less frustration, 30% drop in opioid use". On 08/21/03, the patient is reported as having "less pain, less spasms, improved range of motion. Decreasing medication use without withdrawal symptoms. Anxiety better, depression slowly improving". Therefore, it is determined that the proposed chronic pain management program three-to-six times per week for 20 sessions is medically necessary.

This decision by the IRO 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) 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)).

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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 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, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

cc: Program Administrator, Medical Review Division, TWCC

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 13th day of November, 2003.

Signature of IRO Employee:

Printed Name of IRO Employee: