

November 11, 2004

Re: **MDR #:** M2-05-0147-01 **Injured Employee:**
TWCC#: **DOI:**
IRO Cert. #: **SS#:**

TRANSMITTED VIA FAX TO:

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT:

TREATING DOCTOR:

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management and in Neurology and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's
Information provided by Respondent:

- Peer review 07/07/04
- Documentation and correspondence

Information provided by Treating Doctor:

- Office notes 06/06/02 – 09/14/04
- Operative reports 07/16/02 – 11/05/02
- Radiology reports 05/01/02 – 05/16/02

Information provided by rehab center:

- Assessments 03/11/04 – 08/17/04
- Physical therapy notes 04/29/04 – 08/20/04

Clinical History:

This claimant sustained injury in a work-related accident on _____. The patient was eventually diagnosed as having a disc bulge in the lumbar spine, but has not undergone surgery. She has undergone epidural steroid injections as well as injections into the right carpal tunnel, with no relief that has been sustained. The patient was eventually seen in some individual sessions with a psychologist from which she reported some benefit; therefore, she was referred for a chronic pain program for a multidisciplinary approach utilizing therapy as well as physical rehabilitation, etc. There has been some mention of psychological co-morbidity such as depression, though it is not entirely agreed upon as to the relationship of the psychological condition with her work-related injury. She has been treated with antidepressants as well. The claimant has already undergone 10 sessions of a chronic pain management program with no clear-cut evidence of improvement in that time.

Disputed Services:

Chronic pain management 5 X weekly X 4 weeks, or 20 sessions.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the chronic pain management program in dispute is not medically necessary in this case.

Rationale:

This claimant may benefit from a multidisciplinary pain management program that addresses both physical as well as psychological consequences of the chronic pain condition. However, this should consist of an appropriate physical therapy and exercise program targeting the area of the body that has discomfort. This should not consist primarily of just passive modalities, as these will not result in any long-term benefit.

Biofeedback, behavioral modification, and group therapy, as well as individual psychotherapy can also be beneficial. Medication adjustments can also be made during the chronic pain program, such as titration of antidepressants with appropriate reduction in the usage of pain medications if possible, etc. Therefore, I do feel that this claimant can be appropriately referred for a chronic pain management program that is multidisciplinary, as long as it does offer appropriate levels of physical therapy that is the primarily an active program, counseling, behavioral modification, etc. The records provided for review did not present documentation that the proposed pain management program included these components.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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
Texas Workers' Compensation Commission, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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.

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 November 11, 2004.