MCMC

IRO Medical Dispute Resolution M2 Prospective Pre-Authorization
IRO Denial Notification Letter

Date: December 10, 2004.
Injured Employee:
MDR #: M2-05-0211-01
TWCC #
MCMC Certification #: 5294

Requested Service: Proposed 30 days pain management program.

MCMC llc (MCMC) is an Independent Review Organization (IRO) that has been selected by The Texas Workers' Compensation Commission (TWCC) to render a recommendation regarding the medical necessity of the above requested service.

Please be advised that a MCMC Physician Advisor has determined that your request for M2 Prospective Medical Dispute Resolution on 12/16/2004 concerning the medical necessity of the above requested service is hereby Denied based on:

*table of disputed services
*Shorman Solutions Clinical Advisor UR letter dated 08/23/2004, 07/27/2004, 10/15/2004
*Report of medical evaluation dated 07/17/1998
*Manual Medicine letter from Dr. F dated 07/16/1998 and 07/17/1998
*Houston Spine and Rehab institute medical report dated 06/22/2004, 05/19/2003, 11/07/2002, 02/11/2003,
*Physical Medicine and Rehab physical performance test dated 07/13/2004
*Positive Pain Management psychological eval report 07/13/2004
*First report of injury
*Houston Spine and Rehab medical report dated 12/18/2003
*Review Med medical record review dated 09/05/2003
*Referral form to chronic pain management program dated 07/01/2004
*Shorman Solutions preauthorization advisor review from dated 08/17/2004
*Positive Pain Management pre-authorization request dated 08/16/2004
*Positive Pain Management request for appeal letter dated 08/16/2004
*Positive Pain Management Physical performance eval request for initiation pain program dated 07/13/2004
*Positive Pain Management treatment plan dated 07/22/2004

The medical necessity of the requested 30 day pain management program is not established within the documentation. Firstly, it is not obvious from a review of the documentation that all lower forms of treatment have been exhausted. For participation in this tertiary level program, all other lower forms of care should have been attempted and reviewed as to efficacy. It is obvious, for example, that the injured individual was administered one injection, however the response to the injection is not included in the submitted documentation or rationale as to why additional injection therapy was not

attempted. Serial injection therapy can be an effective pain management tool especially in chronic cases such as this where one or more surgeries have been attended.

Also, there is conflicting information as to the injured individuals psychological condition. A psychological report dated 07/13/2004 reflects an opinion that the injured individual was suffering from depression and a non-specific psychological condition, however self reporting inventories dated 07/13/2004, the exact same date, reflect no psychosocial overlay, no depression, and no anxiety. This apparent conflicting information is not explained in the documentation. There is a significant psychosocial component to the proposed chronic pain management program.

Also, as opined previously, the requested extent of the program, 30 days, is not consistent with established protocols and standards of care and application within the established medical community. This is especially true given the fact that the injured individual has already participated in 6+ weeks of a multidisciplinary work hardening program.

Moreover, a physical performance evaluation dated 07/13/2004 revealed functional deficits, however also revealed some high coefficients of variation in some functional elements of the exam. In addition, the injured individual demonstrated a positive rapid exchange grip test which, according to the report itself, may be an indicator of submaximal effort. These test results would certainly threaten the success of the proposed program.

Lastly, the requested pain management program has a significant physical therapy component. It is not obvious from a review of the documentation that the injured individual has, in the past, benefited from any physical therapy from an objective standpoint. It could not be reasonably expected, therefore, that that injured individual would be positively impacted from this specific component of the pain management program.

Given the issues raised in the above discussion, the medical necessity of the requested pain management program is not established.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5).

The reviewing provider is a Licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

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 or your receipt of this decision (28Tex.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) days of your receipt of this decision (28Tex.Admin. Code 148.3©.)

This decision is deemed received by you 5 (five) days after it was mailed (28Tex.Admin. Code 102.4(h)**(2)** or 102.5(d)). A request for a hearing **and a copy of this decision** should 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 the decision shall deliver a copy of its written request for a hearing to all other parties 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

__16___ day of __December____ 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee:_____