

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

**SOAH DOCKET NO. 453-05-2923.M2**

November 10, 2004

**NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M2-05-0214-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- 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 male who sustained a work related injury on ----- . The patient reported that while at work he injured his back when he attempted to lift a piece of steel and it fell on him. Treatment for this patient's condition has included active and passive physical therapy, rehabilitation, steroid injections, medication management and a reported 6 surgeries. The patient continues with complaints of chronic back pain. An initial visit comprehensive evaluation report from 10/7/99 reported the patient's working diagnoses as failed back surgery syndrome with chronic low back pain and lumbar radiculopathy, and myofascial pain syndrome of the lower back secondary to the failed back surgery. A psychological evaluation performed on 7/9/04 indicated the diagnoses of depressive disorder, psychological disorder associated with a medical condition, chronic pain and moderate ongoing physical difficulties producing a disruption in his lifestyle and psychological difficulties. The patient has been recommended for a chronic pain management program.

## Requested Services

Chronic pain management program.

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

### *Documents Submitted by Requestor:*

1. Request for Appeal 8/16/04
2. Psychological Evaluation 7/9/04
3. Treatment Plan 7/23/04
4. Follow Up Office Visit note 6/2/04
5. Operative Note 11/16/99
6. Initial Visit Comprehensive Evaluation 10/7/99

### *Documents Submitted by Respondent:*

1. RS Medical Prescription 1/29/04
2. Biomechanical Report 12/5/03, 10/10/03, 8/1/03
3. Letter of Medical Necessity (no date)
4. Office Note 9/22/03, 12/1/03, 11/5/03
5. Physical Performance Test 7/9/04

## 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 41 year-old male who sustained a work related injury to his back on ----- . The ----- physician reviewer indicated that the diagnoses for this patient's condition has included failed back surgery syndrome, lumbar radiculopathy, and myofascial pain syndrome. The ----- physician reviewer noted that the treatment for this patient's condition has included active and passive physical therapy, rehabilitation, epidural steroid injections, medication management and 6 surgeries. The ----- physician reviewer also noted that the patient had underwent a psychological evaluation and has been diagnoses with a depressive disorder/psychological disorder associated with a medical condition and chronic pain syndrome. The ----- physician reviewer further noted that the patient has been recommended for a chronic pain management program. The ----- physician reviewer explained that the patient has exhausted conservative and interventional therapies. The ----- physician reviewer noted that the patient continues with daily low back pain and has developed significant depression. The ----- physician reviewer explained that the patient would receive maximal treatment in a pain management program to assist in the development of self regulation and improved functional capabilities. The ----- physician reviewer indicated that the requested program would provide physical strengthening, therapeutic exercise, intensive psychotherapy, counseling with an emphasis on pain control, medication usage and vocational goal development. Therefore, the ----- physician consultant concluded that the requested chronic pain management program 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,

-----

State Appeals Department

cc: Texas Workers Compensation Commission

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 10th day of November 2004.

Signature of IRO Employee

Name