

December 1, 2004

Re: **MDR #:** M2-05-0231-01 **Injured Employee:**
 TWCC#:
 IRO Cert. #: 5055 **DOI:**
 SS#:

TRANSMITTED VIA FAX TO:

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

REQUESTOR:
RESPONDENT:

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 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 Requestor:

- Office notes 03/09/04 – 09/16/04
- Physical therapy notes 06/02/04 – 09/29/04
- FCE 06/15/04
- Nerve conduction study 02/04/04
- Operative report 06/18/04
- Radiology reports 11/28/04 – 09/30/04

Information provided by Respondent:

- Case summary
- Medical record review 06/03/04
- Designated doctor exam & impairment rating 02/09/04

Information provided by Orthopedist:

- Office notes 04/05/04 – 07/29/04

Information provided by Chiropractor:

- Letter of medical necessity 02/24/04
- Office notes 12/29/03 – 03/01/04
- Physical therapy notes 01/12/04 – 01/24/04

Information provided by Pain Mgmt. Specialist:

- Consultations 04/29/04 & 05/20/04

Information provided by Neurosurgeon:

- Consultation 02/12/04

Information provided by Pain Mgmt. Specialist:

- Office notes 11/28/03 – 12/15/03

Clinical History:

The claimant sustained a work-related injury on ____ in which injured her neck and lower back. There are radiating symptoms in the upper and lower extremities as well. She had been treated with medications including Soma, Ultracet, Ibuprofen, propoxyphene, cyclobenzaprine, Zoloft, Celebrex, and Lexapro. She has undergone treatments with injections into the spine, as well as physical therapy including work conditioning, as well as some individual psychotherapy. She continues to suffer from this severe pain that is impacting her daily activities as well as her ability to function in an occupation, etc. There also has been a psychological/emotional consequence to her chronic pain, including symptoms of anxiety as well as depression.

Disputed Services:

Thirty-session outpatient chronic pain management multidisciplinary program, 5 X weekly for 6 weeks (97799).

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the pain management program in dispute as stated above is medically necessary in this case.

Rationale:

It appears that this claimant has undergone multiple treatment trials, including multiple medications, with continued use of analgesics. Other treatment attempts have included injections into the cervical and lumbar spine, physical therapy, and some individual psychotherapy. She continues to be troubled not only with ongoing pain, but also an interference with her abilities to resume day-to-day functioning both at home and at work, along with some psychological manifestations of the chronic pain and the impact that this has had on her life.

For all of these reasons, the reviewer feels that the claimant would be an ideal candidate for a multidisciplinary chronic pain program. Not only may she be provided with some reduction in her pain, but will also gain tools to improve her functionality despite her pain still being present. Additionally, there may be some continued emphasis on her psychological consequences from her chronic pain with the usage of biofeedback, individual and group therapy, as well as medication adjustments for depression, anxiety, etc. Hopefully, the claimant will

be able to reduce some of her analgesic usage by the end of the program as well. Physical therapy and an active exercise program should also be an important portion of this chronic pain program. The reviewer believes that this type of program would be reasonable for this claimant and her presentation.

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 December 1, 2004.