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NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 3, 2005

Requester/ Respondent Address: TWCC
Attention: Dee Torres
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-1609

Advantage Healthcare Systems
Attn: Nick Kempisty
Fax: 214-943-9407
Phone: 214-943-9431

Texas Mutual Insurance Co
Attn: Ron Nesbitt
Fax: 512-404-3980
Phone: 512-322-8518

RE: Injured Worker:
MDR Tracking #: M2-05-1580-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 Psychiatric reviewer (who is board certified in psychiatry) who has an ADL certification. The 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 for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- 154 pages of medical documentation

Submitted by Respondent:

- Items listed Exhibit #1 through Exhibit #5

Clinical History

The claimant injured his back on _____. Since that time he has had extensive diagnostic evaluations, conservative treatments, injections, and surgical repair of his lumbar injury. He has had persistent pain. At one point he apparently was evaluated by the PRIDE chronic pain management program (CPMP) and recommended for treatment there. Whether he had treatment there or not is not included in the documentation. According to the one of the utilization review letters, he had 10 sessions of a CPMP in April and May of 2004 and the second set in January and February of 2005. The other non-authorization letter indicates that the claimant has had a total of 30 sessions of CPMP. The treatment notes that are included by the provider indicate that 10 sessions were done from the period of February to March of 2005.

Requested Service(s)

Ten sessions of chronic pain management

Decision

I concur with the carrier that continued CPMP is not medically necessary.

Rationale/Basis for Decision

The claimant apparently has participated in at least 20, if not 30, sessions of chronic pain management programming. Tertiary pain management programs are supposed to teach individuals the skills that they can continue to employ following discharge to gradually reach their treatment goals. A 20 or 30 session program would be typical durations for this treatment modality. Despite the claimant having had the number of sessions that would typically make up a complete CPMP program, the notes reviewed from the program suggest that the claimant is making minimal gains. He is still highly symptomatic with depression and anxiety. The pain level is only minimally changed and his global assessment functioning remains unchanged. Thus, he does not appear to be responding to this tertiary type of intervention.

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)).

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 a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
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 other party involved in this 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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 3rd day of June 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder