

June 9, 2005

VIA FACSIMILE
Positive Pain Management
Attn: Heidi Wilson

VIA FACSIMILE
TASB Risk Management
Attn: Jackie Rasga

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-1631-01
TWCC #:
Injured Employee:
Requestor: Positive Pain Management
Respondent: TASB Risk Management
MAXIMUS Case #: TW05-0103

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS 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 MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on _____. The patient reported that while at work she injured her back while she was emptying a large bowl. The diagnoses for this patient have included lumbago, lumbosacral neuritis or radiculitis. Treatment for this patient's condition has included massage therapy, TENS unit, injection therapy, passive and active physical therapy, chiropractic treatment, other passive modalities and oral medications. The patient has reported continued pain rated as a 9/10. She has been recommended for participation in a chronic pain management program, 30 sessions.

Requested Services

30 sessions chronic pain management program.

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

Documents Submitted by Requestor:

1. Letter to TASB 4/11/05
2. Psychological Evaluation Report 3/15/05
3. Overview of the Psychological Assessment (no date)
4. Physical Performance Evaluation 3/15/05

Documents Submitted by Respondent:

1. Peer Review 4/7/05
2. Positive Pain Management Program Description
3. Office and Treatment notes 9/8/97 – 1/20/98
4. MRI report 1/13/98
5. Initial FCE 4/6/98

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury to her low back on _____. The MAXIMUS physician reviewer indicated that the diagnoses for this patient have included lumbago, lumbosacral neuritis, and radiculitis. The MAXIMUS physician reviewer noted that the patient has been treated with massage therapy, a TENS unit, passive and active physical therapy, chiropractic treatment, injection therapy and oral medication. The MAXIMUS physician reviewer also noted that a formal psychological evaluation determined that the patient has a depressive disorder directly related to her chronic pain condition. The MAXIMUS physician reviewer further noted that a chronic pain management program has been recommended for further treatment of her condition. The MAXIMUS physician reviewer explained that the documentation provided clearly indicates that the patient has a chronic pain condition directly related to her work related injury. The MAXIMUS physician reviewer noted that the patient has continued complaints of pain rated at a 9/10. The MAXIMUS physician reviewer also noted that conservative and interventional therapies have failed. The MAXIMUS physician reviewer explained that this patient would benefit from a multidisciplinary approach to pain control and that participation in a multidisciplinary chronic pain management program that combines psychological components with functional restoration would improve this patient's functional status. Therefore, the MAXIMUS physician consultant concluded that the requested 30 sessions 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,

MAXIMUS

Elizabeth McDonald
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 9th day of June 2005.

Signature of IRO Employee: _____
External Appeals Department