

July 29, 2005

**Re: MDR #:** M2-05-1827-01 **Injured Employee:**  
**TWCC#:** **DOI:**  
**IRO Cert. #:** 5055 **SS#:**

**TRANSMITTED VIA FAX TO:**  
**Texas Workers' Compensation Commission**  
Attention:  
Medical Dispute Resolution  
Fax: (512) 804-4868

**REQUESTOR:**  
Advantage Healthcare Systems  
Attention: Nick Kempisty  
(214) 943-9407

**RESPONDENT:**  
Royal Insurance Co.  
c/o Cunningham Lindsey  
Attention: Tom Lang  
(512) 452-7004

**TREATING DOCTOR:**  
John Sazy, MD  
(817) 468-7876

Dear Mr. \_\_\_\_:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI 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 Independent Review, Inc. 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 a board certified in Physical Medicine & Rehabilitation and in Pain Medicine and is currently listed on the TWCC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. 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:

Texas Workers' Compensation Commission  
Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 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.

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 July 29, 2005.

Sincerely,

Gilbert Prud'homme  
General Counsel

GP/th

**REVIEWER'S REPORT  
M2-05-1827-01**

**Information Provided for Review:**

TWCC-60, Table of Disputed Services, EOB's

From Requestor:

Correspondence  
Office note 04/04/05  
Physical performance test 04/06/04

From Respondent:

Correspondence

From Treating Doctor:

Office notes 03/24/98 – 05/19/05  
Nerve conduction study 06/04/04  
Operative report 03/06/00

**Clinical History:**

This male patient suffered a work injury on \_\_\_\_\_. This resulted in a back injury, which ultimately was treated with four surgeries and a comprehensive variety of conservative therapies. His treating physician has requested pain management.

**Disputed Services:**

Ten sessions of chronic pain management program.

**Decision:**

The reviewer agrees with the determination of the insurance carrier and is of the opinion that a pain management program as stated above is not medically necessary in this case.

**Rationale:**

It is not clear that the injured worker would benefit from the proposed therapy. The LPC who examined him opines that the patient's use of medication is a "maladaptive coping strategy," yet he doesn't provide any protocol for medication withdrawal. He finds the patient to have "severe depression," but mentions treatment only with clinical tools, and not with antidepressant medication, which along with psychotherapy, is a mainstay in the treatment of depression. The proposed program seems to be limited by unrealistic and incomplete plans, and therefore would not be in this patient's best interest.