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## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** July 1, 2005

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

Canton Chiropractic Clinic  
Attn: Nick Kempisty  
Fax: 214-943-9407  
Phone: 214-943-9431

Travelers Property Casualty Insurance Co  
Attn: Jeanne Schafer  
Fax: 512-347-7870  
Phone: 512-328-7055

**RE: Injured Worker:**  
**MDR Tracking #:** M2-05-1877-01  
**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:**

- There was no documentation submitted by the requester

### **Submitted by Respondent:**

- Notice of IRO assignment
- Letter from the carrier
- Diagnostic studies including an MRI scan of the lumbar spine, bone scan, EMG/NCVs, FCEs
- Treatment notes from the initial treating provider, Dr. McCaskill
- Evaluation by Dr. Hutchison
- Evaluation by Dr. Xeller
- Evaluation and treatment notes from Dr. Jackson
- Evaluation notes from the Canton Health Care Systems
- Designated doctor evaluation by Dr. Jones

### **Clinical History**

The claimant was injured in a fall where he hit his back on \_\_\_\_\_. He was treated with conservative treatment, but reported progressive pain and the development of other symptoms including seizures, upper extremity pain, tremor, depression, diabetes, and hypertension. He has been on a number of different medications including medications for pain, seizures, depression and muscle spasm but, as of the most recent evaluation, continues to report severe disabling symptoms. On 3/15/05, the Canton Health Care Systems evaluated him. They noted severe depression with suicidal ideations and plans. They noted severe anxiety. His mental status examination, however, is noted to be hyperalert with rapid speech. Their diagnosis for him is a chronic pain disorder. They recommended treatment with a chronic pain management program. The claimant's most recent medical evaluation was with Dr. Jones on 3/17/05. He believed the claimant should have additional work up for reflex sympathetic dystrophy and possibly a sympathetic nerve block if this was positive. He also felt the claimant should be seeing a neurologist for evaluation of his neurologic complaints. He noted signs of symptom magnification, which had been noted by a number of other examiners as well.

### **Requested Service(s)**

Ten sessions of a chronic pain management program

### **Decision**

I agree with the carrier that the services in dispute are not medically necessary at this juncture.

### **Rationale/Basis for Decision**

There are a number of reasons that participation in the chronic pain management program is not indicated currently. The first reason is that there have been a number of recent recommendations for additional diagnostic work up that indicate that many of the providers that have evaluated him do not feel the claimant is at a tertiary level of care. Chronic pain management programs are tertiary level interventions. Secondly, there are indicators in a number of the examinations that indicate symptom exaggeration. There has not been an adequate psychological evaluation to assess to what extent primary and secondary gain issues are at play in this case. If these are present, the claimant

would be unlikely to benefit from a chronic pain management program. Third, the claimant is reported to have severe depression with suicidal ideations. While depression is not uncommon in individuals who enter a chronic pain management program, if his depression is truly of the depth indicated, it is likely to interfere with his full participation in the programming. In an individual with depression of this claimant's severity, intensive medication management would be warranted. This was not indicated as part of the plan submitted by the program.

## **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 1<sup>st</sup> day of July 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder