



7600 Chevy Chase, Suite 400
Austin, Texas 78752
Phone: (512) 371-8100
Fax: (800) 580-3123

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 6, 2005

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

/Injury 1 Treatment Center
Attn: James Odom
Fax: 214-692-6670
Phone: 214-692-6666

ESIS
Attn: Raynetta Martin
Fax: 713-403-3139
Phone: 713-403-3144

RE: Injured Worker:
MDR Tracking #: M2-05-1443-01
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 Psychologist reviewer. 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:

- Requester's position on pre-authorization
- Pre-authorization request and interdisciplinary pain treatment program description

May 6, 2005

Page 2

- Peer review denial notice regarding original request
- Peer review denial notice regarding appeal
- Chronic pain management plan and goals of treatment
- Referral by Ronald D. Linderman, D.C.
- Health and physical assessment by David Schickner, M.D.
- Physical therapy evaluation – chronic pain management program
- Physical performance evaluation
- Psychophysiological assessment
- Initial behavioral medicine consultation of 11/17/04
- EMG report of 3/5/94
- Lumbar myelogram and post myelogram CT scan report of 3/25/94
- EMG report of 12/14/93
- MRI of the lumbar spine of 12/8/01
- CT scan of the cervical spine, post myelogram of 11/8/95
- Cervical myelogram of 11/8/95

Submitted by Respondent:

- Requester's position on pre-authorization
- Carrie notes regarding services requested and decisions
- Peer review denial of the original request
- Peer review denial of the appeal
- IME of Hugh Ratliff, M.D. of 11/22/04

Clinical History

The claimant was injured on ___ while working for _____ as an electrical technician. He was pulling a 500 pound test line with wire on it and injured his back. He was evaluated and treated for his back injury. On 1/4/94, he was re-evaluated and also found to complain of upper extremity symptoms. He continued with evaluation and conservative treatment. On 1/26/96, he was found to be at MMI and awarded an 8% whole person impairment. On 4/12/96, the cervical spine was also rated, resulting in a 23% whole person impairment. On 11/17/04, he was referred by Dr. Linderman for a behavioral medicine consultation. Individual psychotherapy was recommended and authorized. After individual psychotherapy was completed, a request for authorization of an interdisciplinary pain treatment program was made. The request was denied initially and on appeal.

Requested Service(s)

Ten sessions of a chronic pain management program.

May 6, 2005

Page 3

Decision

I disagree with the carrier and find that the services in dispute are medically necessary.

Rationale/Basis for Decision

As pointed out in the provider's position paper, the claimant does meet criteria for suitability for a chronic pain management program. The inconsistency between the claimant's subjective complaints and objective signs is the basis for the diagnosis of chronic pain syndrome. It is for this diagnosis that chronic pain management programs were developed. Therefore, I believe that the requested treatment is reasonable and necessary. (Clinical Practice Guidelines for Chronic Non-Malignant Pain Syndrome Patients, II: An evidence based approach. Journal of Back and Musculoskeletal Rehabilitation, 1999, January 1:13:47-58)

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.

May 6, 2005

Page 4

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 6th day of May 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder