

  
**INDEPENDENT REVIEW INCORPORATED**

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**June 27, 2006**

**Re: MDR #: M2 06 1407 01 Injured Employee: \_\_\_**  
**DWC #: \_\_\_ DOI: \_\_\_**  
**IRO Cert. #: 5055 SS#: \_\_\_**

**TRANSMITTED VIA FAX TO:**

**TDI, Division of Workers' Compensation**

Attention: \_\_\_

Medical Dispute Resolution

Fax: (512) 804-4868

**RESPONDENT: Service Lloyds Ins.**

**REQUESTOR: George Easterly, LPC**

**TREATING DOCTOR: John McConnell, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this 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 office manager 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 the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before 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 orthopedic surgery and is currently listed on the DWC Approved Doctor List.

P.O. Box 855  
Sulphur Springs, TX 75483  
903.488.2329 \* 903.642.0064 (fax)

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

### Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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 June 28, 2006.

Sincerely,



Jeff Cunningham, DC  
Office Manager

**REVIEWER'S REPORT  
M2 06 1407 01**

**Information Provided for Review:**

1. TWC assignment.
2. Medical dispute resolution request/response.
3. Table of disputed services.
4. Preauthorization determination from Corvel Corporation.
5. Records from requestor.

**Clinical History:**

A comprehensive multidisciplinary chronic behavioral pain management program was requested for \_\_\_\_\_. This was denied by the insurance carrier as medically unnecessary. The patient has a history of an injury to the neck, lower back, and right shoulder and has undergone arthroscopic shoulder surgery in October 2005 as well as multiple epidural steroid injections in the cervical spine. The patient continued to have chronic pain and use of narcotic analgesics. The patient has not responded to previous medical care. Individual psychological analysis of the patient determined severe stress and depression related to this injury.

**Disputed Services:**

Comprehensive multidisciplinary chronic pain behavioral pain management program with 10 sessions.

**Decision:**

I DISAGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

**Rationale:**

An extensive review of the medical records show that this patient suffered a work-related injury causing chronic pain in the shoulder; neck, lower back, and both legs. The patient failed extensive conservative management including physical therapy and chiropractic adjustments including multiple modalities. He underwent multiple surgical procedures including a shoulder arthroscopy and 3 separate cervical epidural injections. The patient was unable to return to work due to chronic pain, depression, and anxiety. Based on this patient's psychological profile as well as numerous criteria such as his excessive dependency on pain medication, his previous poor response to medical care, the interference of his current pain with his physical, psychological, social, and vocational

functioning, and his high levels of stress and depression, the patient is an excellent candidate for multidisciplinary pain management behavioral program.

**Screening Criteria/Guidelines Used:**

“Clinical Practice Guidelines for Chronic Nonmalignant Pain Syndrome” found in The Journal of Back Musculoskeletal Rehabilitation, January 1999, were used as authorization guidelines in this decision.