

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-05-1227.M2**

September 17, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-04-1675-01
IRO Certificate #: 5348**

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

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

Clinical History

This case concerns a 48 year-old female who sustained a work related injury on ___. The patient reported that while at work she injured her shoulders, right upper back and neck. A MRI of the cervical spine was performed on 5/23/03 that indicated mild posterior herniations, C3-4 through C7-T1. An EMG/NCV performed on 6/24/03 revealed cervical radiculopathy. On 8/12/03 the patient underwent a fluoroscopic needle localization, cervical epidurogram, cervical deposition of a non-neurolytic substance (triamcinolone/0.25% bupicacaine) multilevel with a Racz-Brevi cath at C4-C7 and C7-T1 for the diagnoses of cervical disc disease with bilateral upper extremity polyradiculopathy. The diagnoses for this patient have included brachial neuritis or radiculitis, nos, cervical radiculitis, intervertebral disc disorder, and displacement of cervical intervertebral disc with out myelopathy. Treatment for this patient's condition has included epidural injections, medications, physical therapy, chiropractic treatment, massage therapy and ultrasound.

Requested Services

Chronic Pain Management Program times 20 sessions.

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

Documents Submitted by Requestor:

1. Operative Note 8/12/03
2. EMG/NCV report 6/24/03
3. MRI report 5/23/03
4. Mental Health Evaluation 4/27/04

Documents Submitted by Respondent:

1. Progress Note 12/15/03 - 2/9/04
2. DDE 12/1/03
3. Progress summary 10/13/03- 3/4/04

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 48 year-old female who sustained a work related injury to her shoulders, right upper back and neck on ____. The ___ physician reviewer indicated that an MRI performed on 5/23/03 demonstrated mild posterior herniations, C3-4, C7-T1, and that an EMG/NCV performed on 6/24/03 revealed cervical radiculopathy. The ___ physician reviewer noted that the diagnoses for this patient have included cervical disc disease, brachial neuritis/radiculitis, and cervical radiculitis. The ___ physician reviewer also noted that the treatment for this patient has included medical therapy, physical therapy, massage therapy, chiropractic treatment, ultrasound therapy, a series of 2 epidural steroid injections, and cervical epidurogram/deposition of an non-neurolytic substance (triamcinalone/0.25% bupicacaine) multilevel with Racz-Brevi cath at C4-5, C5-4, C6-7 and C7-T1. The ___ physician reviewer indicated that the patient has continued complaints of shoulder, back and neck pain. The ___ physician reviewer noted that a psychological evaluation revealed adjustment disorder with depressed mood, and a pain disorder associated with both psychological factors and a general medical condition. The ___ physician reviewer explained that the documentation demonstrates that the patient has a work related chronic pain disorder. The ___ physician reviewer indicated that the patient has tried and failed multiple conservative and interventional therapies and continues with pain complicated by an adjustment disorder with depressed mood.

The ___ physician reviewer explained that the patient would benefit from a multidisciplinary approach to pain management that would include individual psychotherapy, group psychotherapy, biofeedback, vocational counseling, nutritional counseling, exercise, aqua therapy and physical therapy. The ___ physician reviewer also explained that the goals of this program would be to decrease pain, decrease use of medications, decrease symptoms of depression and anxiety and increase function. Therefore, the ___ physician consultant concluded that the requested chronic pain management program times 20 sessions 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,

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 17th day of September 2004.