MDR Tracking Number: M5-03-0031-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Pain Management Program was not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that Pain Management fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 9/21/01 to 2/18/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 1st day of May 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

April 22, 2003

Re: Medical Dispute Resolution
MDR #: M5-03-0031-01

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is Board Certified in Anesthesiology and Pain Medicine.

Clinical History:
This female claimant sustained injury to her cervical spine in a work-related injury on ___. MRI of the cervical spine on 08/14/00 revealed a 3.0 mm herniation at C5-6. A CT of the lumbar spine on 01/25/02, status post fusion at L-4, L-5, and S-1. There is a screw over the roof of the right S1-2 foramina. She has chronic pain and severe depression.

Disputed Services:
Pain management program.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the program in question was not medically necessary in this case.

Rationale for Decision:
The excessive duration of the pain management program is a major concern. Most of the more successful programs are much shorter. From the clinical notes, there is no clear evidence that the patient made significant improvement throughout the program. On 11/27/01, she was hospitalized for suicidal ideation. A note dated 11/19/01 reported a 50-pound weight gain since injury to that date. An 11/07/01 group therapy note quotes “minimal motivation”. On 10/26/01, pain diagrams showed total-body pain with the scale indicated as 7 out of 10.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional 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 case for determination prior to referral to the Independent Review Organization.

Sincerely,