

NOTICE OF INDEPENDENT REVIEW DECISION

May 13, 2002

Requestor

Respondent

RE: Injured Worker:

MDR Tracking #: M2-02-0598-01

IRO Certificate #: 4326

___ 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 ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ 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 ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. 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.

Clinical History

This 51 year old female was injured on ___ when she missed sitting in a chair and fell on the floor. The patient has had treatment interventions including epidural steroid injections and nerve blocks. The treating physician has recommended that the patient undergo a 20 day pain management functional/restoration program.

Requested Service(s)

20 day pain management functional /restoration program

Decision

It is determined that the 20 day pain management functional/restoration program is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had physical and behavioral aspects of treatment and those are major components of the 20 day restoration/functional program. Since there has been no significant improvement with the major components of the 20 day program, there is likely to be little gained from the program.

This decision by the IRO 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. A request for 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 hearing, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, Texas 78704-0012.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

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 _____ day of _____ 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: