

June 19, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0612-01
IRO Certificate No.: 5055

Dear

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records 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. Your case was reviewed by a doctor of Chiropractic Medicine.

I DISAGREE WITH THE DETERMINATION BY THE UTILIZATION REVIEW AGENT ON THIS CASE. CHRONIC PAIN MANAGEMENT FIVE (5) TIMES A WEEK FOR A FOUR (4) WEEK DURATION, TO COMPLETE THIRTY (30) SESSIONS IS MEDICALLY NECESSARY.

I am the Secretary and General Counsel of ___ 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 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.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days of your receipt of this decision** (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) 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
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

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.

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 October 16, 2002.

Sincerely,

Secretary & General Counsel

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0612-01, in the area of Chiropractic Rehabilitation. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of 30 sessions (6 hours/day, 5 days/week) Chronic Pain Management Program.
2. Correspondence and designated doctor evaluation.
3. _____ office notes.
4. Psychological evaluation performed by _____
5. Physical therapy notes, _____
6. Biofeedback progress notes: _____

B. SUMMARY OF EVENTS:

The patient was working for ___ as a reservations agent when she injured herself on ___.

The patient was diagnosed with bilateral carpal tunnel syndrome and had a carpal tunnel release on the right wrist in August of 2000 and a carpal tunnel release on the left wrist in February of 2001.

___ attempted work hardening applications, but the patient was removed due to increased symptomatology.

The patient underwent ten sessions of biofeedback therapy, and this application was moderately successful. ___ has attempted on numerous occasions to pre-authorize an additional FCE with no success to determine current functional status.

On 11/12/01 and again on 12/18/01, ___ office was denied Chronic Pain Management Program applications by ___ agents. The basis of the denial on both occasions centered around the fulfillment of medical necessity.

C. OPINION:

1. I DISAGREE WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENTS ON THIS CASE ABOUT THE ISSUE OF MEDICAL NECESSITY.

I believe the patient meets the admitting criteria to undergo Chronic Pain Management services at the schedule set forth by ___ office (5 times/week, for a 4-week duration, to complete 30 sessions).

2. I further believe that the patient's lack of significant improvement with the carpal tunnel releases to the right and left hands displays medical necessity for the introduction of pain management/coping strategies. These pain management/coping strategies are the basis of a Chronic Pain Management Program and must be explored in this patient's case due to the lack of significant improvement with surgical intervention.
3. Medical necessity, I believe, was met on 10/30/01 when the designated doctor stated that the patient had suffered a functional impairment to her wrists bilaterally and that a pain management program may be warranted. The patient was given a significant impairment of 18% which correlates with a

high degree of dysfunction bilaterally over the upper quarter. The standard of care would require a patient with a functional deficit this great to be significantly trained in the management of their pain and methodology given to the patient to cope with a permanent dysfunction.

4. In addition, other practitioners from multiple disciplines stated that enrollment into a Chronic Pain Management Program was an appropriate recommendation. ___ stated that the patient was an excellent candidate for chronic pain management on 12/05/01.
5. The types of screening criteria utilized take reference with Delphi Rehabilitation Protocols of the American Chiropractic Rehabilitation Board, referral data noted in this review, Medical Fee Guidelines, and clinical experience.

D. ADDITIONAL COMMENTS:

It is the opinion of this reviewer that medical necessity for enrollment in a Chronic Pain Management Program was met when the patient failed surgical intervention on both the right and left wrists. The patient was given an 18% impairment over the left and right wrists and upper quarter. In the review of this case, it is unlikely that the patient will return to her occupation. Thus, it is likely that a number of psychosocial issues will have arisen.

The carrier's failure to see potential psychosocial hazards in this case is inexcusable.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 17 June 2002