

NOTICE OF INDEPENDENT REVIEW DECISION

October 21, 2002

RE: MDR Tracking #: M2-02-0733-01
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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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 45 year old female sustained a work-related injury on ____. While working at the ___ in the maintenance department, she slipped and injured her left leg and low back. She was diagnosed with tears in the anterior cruciate ligament, medial meniscus and lateral meniscus of the left knee, bilateral trapezius muscle spasm and right shoulder contusion. Subsequent to the injury, the patient had two surgeries to repair a torn meniscus of the knee, underwent extensive rehabilitation and had several diagnostic studies. She continues to complain of pain in the right shoulder, left hip, and left knee, neck stiffness, as well as depression. The treating chiropractor recommended chronic pain management for 30 sessions (once a day for 5 days for 6 weeks).

Requested Service(s)

Chronic pain management for 30 sessions (once a day for 5 days for 6 weeks).

Decision

It has been determined that chronic pain management for 30 sessions (once a day for 5 days for 6 weeks) is medically necessary.

Rationale/Basis for Decision

Based on the documentation submitted for review, chronic pain management is medically necessary. Several criteria have been satisfied to warrant chronic pain management, including a multidisciplinary recommendation for the program, functional deficits, psychosocial issues that are relevant in current pain behavior, documentation of failure of prior multidisciplinary therapies and documentation of failed surgeries. In addition, the patient meets and exceeds medical necessity criteria for chronic pain management based on guidelines for psychiatric and psychological conditions of injured or chronically disabled workers established in 1999 by the Washington State department of Labor and Industries. The patient demonstrates a disorder of a psychological chronic pain manifestation that prevents employment in her prior vocation. In addition, according to Clinical Practice Guidelines for Chronic Non Malignant Pain Syndrome Patient II: An Evidence Based Approach, behavioral and psychological therapy interventions are beneficial for patients with chronic non-malignant pain syndrome. These interventions assist patients in making meaningful changes in emotional, cognitive, behavioral and physical issues associated with chronic pain problems. Therefore, chronic pain management for 30 sessions (once a day for 5 days for 6 weeks) is medically necessary.

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.

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** (10) 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 hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 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 (Commission Rule 133.308 (t)(2)).

]Sincerely,