

Re: Medical Dispute Resolution
MDR #: M2-02-0900.01
IRO Certificate No.: IRO 5055

Dear

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 physician. Your case was reviewed by a physician reviewer who is a doctor of Chiropractic Medicine.

THE PHYSICIAN REVIEWER OF YOUR CASE **AGREES** WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE. **A twenty (20) day multi-disciplinary pain management program is not 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 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 August 22, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is ___ for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File ___, in the area of Chiropractic Neurology. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. MDR request, ___, 6/26/02.
2. Reconsideration letter, ___, 2/20/02 and 5/08/02.
3. Denial letter, ___, 1/10/02 through 4/12/02.
4. RME from RMA, dated 10/16/01, ___, received 0%.
5. History and physical exam, ___, dated 03/14/02.
6. Treatment plan, ___, dated 1/29/02.
7. Psychological evaluation report, ___, 1/16/02.
8. DD Exam, ___, dated 12/07/01.
9. SOAP notes, ___, 9/05/01 to 10/24/01.
10. Orthopedic evaluation, ___, 8/10/01.
11. Impairment rating exam, ___, 3/14/02.
12. IR Exam, DPPC, 10/26/01.
13. FCE from ___, dated 10/26/01.

B. BRIEF CLINICAL HISTORY:

The patient is a 25-year-old female who was seen for a work injury on _____. She was working in Housekeeping at the _____. She describes the injury as pulling bedsheets off a bed at which time she had severe pain in her right shoulder. Her complaints were cervical pain, midback pain, and low back pain, as well as shoulder pain. She has been seen by a chiropractor and had MRI studies of the cervical and lumbar spine.

C. DISPUTED SERVICES:

Pre-authorization for a 20-day multi-disciplinary pain management program.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

The patient experienced only a mild muscular sprain/strain that should have healed in seven weeks. On October 16, 2001, she was examined by _____, and he stated she was unable to return to full normal duty at work. Also, on March 12, 2002, she was examined and placed at MMI with no further treatment necessary.

In order to receive admission into a chronic pain management program, according to the Commission of Accreditation of Rehabilitation Facilities (CARF) 1994 Standards Manual the patient must exhibit benefit from the program design, symptoms that meet the description of chronic pain syndrome, and whose medical, psychological, or other conditions do not prohibit participation in the program. The patient has no documented benefit from the program in which she already participated, given the fact that she had little change in her self-rated pain and little change to her ability to deal with stress effectively. She has been examined by a designated doctor, and the conclusion was that she was at MMI, with a 12% impairment Rating.

F. 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.