

October 10, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.1105.01
IRO Certificate No.: I RO 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 health care provider. Your case was reviewed by a physician Certified in Chiropractic Medicine.

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 simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

Clinical History:

The patient is a male suffering from lumboradicular syndrome secondary to herniated nucleus pulposus at L4-L5 following an on-the-job injury. Several doctors, including the use of medications, physical therapy and chiropractic care, have treated him.

Disputed Services:

Thirty (30) sessions of a chronic pain management program.

Decision:

The reviewer partially agrees with the determination of the insurance carrier. The reviewer is of the opinion that fifteen (15) sessions, rather than the requested

thirty (30) sessions, of a chronic pain management program are indicated and medically necessary.

Rationale for Decision:

The patient has documented surgical and MRI notes as well as subjective compliance that would allow him benefit from the program. The level of injury, however, indicates that fifteen (15) sessions of chronic pain management would be sufficient. The patient would also benefit greatly from returning to work on a part-time basis in a modified manner. This alone would greatly improve his ability to return to work in a full-time manner by solely experiencing job re-training skills.

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 11, 2002.

Sincerely,