August 28, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0632-01
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 health care provider. Your case was reviewed by a physician Board Certified in Anesthesia, specializing in pain management

The physician reviewer DISAGREES with the determination made by the insurance carrier in this case. The reviewer is of the opinion that ten (10) session of a chronic pain management program are medically necessary in this case.

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 this 28TH day of August 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0632-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of chronic pain management program for ten (10) sessions.
2. Correspondence.
3. History and physical and office notes.
4. Pain management progress notes.
5. Interdisciplinary progress notes.
6. Radiology reports.

B. BRIEF CLINICAL HISTORY:

The patient is a 65-year-old black male who was involved in a work-related injury while working for the . He apparently

slipped and caught his leg between the frame of the truck and the gas tank after the truck caught on fire, thus injuring his knee. He subsequently underwent arthroscopic surgery by a ___, but has continued to complain of pain in the knee despite physical therapy, work hardening, Synvisc injections, as well as multiple medications and medical efforts.

He attended a pain management program, of which he completed 20 days. This is a 30-day program. Reports would indicate he did remarkably well in this program, but continued to have a lot of pain in the knee. A subsequent MRI was done and showed a torn meniscus in the knee, and efforts are underway to have another arthroscopic surgery done by a ___.

C. DISPUTED SERVICES:

Chronic pain management program for ten (10) sessions.

D. DECISION:

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

E. RATIONALE OR BASIS FOR DECISION:

I would recommend that he complete the final ten (10) days of his pain management program. Once the meniscus is repaired and the knee stabilized, he will likely continue to have some problems with the knee but he should be able to have much greater progress in his situation with the knee working better. I believe, in this case, that the knee has hindered his progress in the pain management program and, therefore, the additional 10 days to complete the pain management program would be indicated.

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.

_____

Date: 27 August 2002