

February 14, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0337-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is a board certified anesthesiologist. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 48 year-old female who sustained a work related injury on ___. The patient reported that while at work she was walking and slipped in some water causing her to fall. The patient reported that she fell backwards landing with her right foot and right knee bent under her. The patient reported that she also fell on her out stretched right hand. The patient reported hearing a pop and feeling immediate pain in her right shoulder and right hand. The patient had an MRI and X-Rays on 2/21/01. The patient has been treated with physical therapy, chiropractic manipulations of her back and knee, and arthroscopy of the right shoulder. The patient also underwent right shoulder manipulation under anesthesiology.

Requested Services

Pain Management Program, additional 10 sessions.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

___ physician reviewer noted that the patient sustained a work related injury ___. ___ physician reviewer indicated that the patient underwent an arthroscopy of the right shoulder as well as manipulation of the shoulder under general anesthesia. ___ physician reviewer noted that the patient completed a course of physical therapy and has received chiropractic

manipulation of her back and knee. ___ physician reviewer also noted that the patient was referred to a pain management program and 30 visits were recommended. ___ physician reviewer explained that the patient completed 20 visits. ___ physician reviewer noted that a review of the documentation from these visits indicates improvement in this patient's complaints of pain and her ability to deal with her chronic pain syndrome on a daily basis. ___ physician reviewer explained that the patient continues to be maintained on medical therapy with Celebrex, Norco, Effexor, and Sonata. ___ physician reviewer also explained that the patient has tried and failed conservative modalities. ___ physician reviewer noted that the patient has benefited from the present comprehensive pain management program. Therefore, ___ physician consultant concluded that the requested pain management program, 10 sessions, is medically necessary to treat this patient's condition at this time.

This decision 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 (ten)** 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 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. (Commission Rule 133.308(t)(2)).

Sincerely,

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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 14th day of February 2003.