

April 15, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-0545-01
IRO Certificate No.: 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ an independent review. ___ 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 who is Board Certified in Physical Medicine and Rehabilitation.

Clinical History:

This 51-year-old female sustained a repetitive overuse-type syndrome in regards to her left upper extremity, shoulder and cervical area. She was diagnosed with a pinched nerve at C-6, for which she underwent surgery in December 2001. She was involved in a lengthy postoperative rehabilitation program with only minimal results.

The patient was then enrolled in a work hardening program consisting of exercise and group counseling. She reported that the noise of the program was bothersome, and she did not like or participate in group therapy. The record indicates that she was already under the treatment of a psychiatrist due to severe depression and anxiety and was on psychotropic medications prior to her enrollment in the chronic pain management program

Disputed Services:

Behavioral/pain management program.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the behavioral/pain management program was not medically necessary in this case.

Rationale for Decision:

The claimant was already enrolled in a multi-disciplinary program, namely a work hardening program that yielded little benefit. The lack of progress or benefit of the work hardening program would indicate that additional psychological group counseling sessions such as that offered in a chronic pain management program would not provide significant benefit. The negative response to her first ten days of therapy would also yield to the conclusion that continuing with another 20 days of the same modalities, which had not proven at all beneficial, would be unnecessary.

It is not reasonable to assume that with the failure of one multi-disciplinary program, enrollment in further multi-disciplinary programs would yield any other benefit. This claimant has received quite extensive psychiatric therapy, psychotropic medications, and group counseling sessions that have provided little relief.

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 care 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.

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 April 15, 2003

Sincerely,