

February 5, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2 03 0602 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed Doctor of Chiropractic who is board certified in Pain Management. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was injured on her job when she fell and injured her right wrist and knee. She was treated for the injury by ___. Treatment included traction, joint mobilization, muscle stimulation and active treatment. EMG was positive for a cervical radiculopathy and carpal tunnel syndrome on the right, but no findings which could be considered consistent with the described injury. MRI of the wrist was negative. The diagnosis by ___ were knee and wrist sprain. ___ was found to be at MMI with 7% whole person impairment on April 9, 2002. The patient's current treating doctor is ___.

REQUESTED SERVICE

The carrier has denied a pain management program, 30 days in length.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

No documentation is presented that indicates this patient has had an ongoing history of depression or chronic pain related difficulties. The patient's first indication of a chronic pain syndrome in this chart is the referral for the program by ____, an orthopedic surgeon. No realistic reasoning for this program could be found in the documentation. The evaluation by ____, was the only sign of chronic pain in this patient's file. The patient is not documented to have ongoing depression, but rather seems to have had a treatment protocol for a sprain/strain injury that has gone on for too long. There is no documentation that would lead me to believe a chronic pain program would have an outcome that is any different from other treatment that has been utilized in this case. No clear goals or structure are presented for review. It is my opinion that the requestor did not demonstrate a need for the requested service and I do not feel that the service would be likely to help this patient return to her workplace.

____ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ____ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ____, I certify that there is no known conflict between the reviewer, ____ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

____ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

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.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes 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 Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 5th day of February, 2003