

February 18, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0624-01

___ 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 board certified in anesthesiology. ___ 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 62 year-old female who sustained a work related injury on ___. The patient reported that while walking in the halls of the school during dismissal time, a student ran in front of her causing the patient to lose her balance and fall. The patient reported that she fell forward on her left knee experiencing immediate pain. The patient had X-Rays showing a comminuted supracondylar fracture of the left femur. The patient underwent an internal rod of the left femur and was hospitalized for two weeks post surgery. The patient has been treated with physical therapy programs, administered various medications, epidural injections and a second surgery to the left knee. The patient complains of constant pain.

Requested Services

Chronic Pain Management Program.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury on ___. The ___ physician reviewer also noted that X-Rays obtained revealed a comminuted supracondylar fracture of the left femur. The ___ physician reviewer further noted the patient underwent

internal roding of the left femur and was hospitalized for two weeks post surgery. The ___ physician reviewer indicated that the member participated in physical therapy post surgery and has been treated for pain with multiple oral medications trials, and serial epidural steroid injections. The ___ physician reviewer noted that the patient underwent a second knee surgery to remove the internal hardware of the knee. The ___ physician reviewer also noted that the patient has also participated in a work hardening program. The ___ physician reviewer indicated that the patient was compliant with all treatments. However, the ___ physician reviewer explained that the patient has complained of daily intense pain for the 19 months post surgery. The ___ physician reviewer indicated that the patient suffers from a chronic pain syndrome that requires a multidisciplinary approach with physical, vocational, and psychological rehabilitation. The ___ physician reviewer explained that the patient has not responded to to any primary or secondary level of care of outpatient treatment. The ___ physician reviewer also explained that the recommended pain treatment program would provide a more structured, intensive multi-disciplinary individualized treatment to deal with the complex mixture of medical and psychological problems associated with her condition. Therefore, the ___ physician reviewer concluded that the chronic pain management program is medically necessary to treat this patient's condition.

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 18th day of February 2003.