

April 14, 2003

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

MDR Tracking #: M2.03.0826.01
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

The patient was injured on her job when she was reaching under her desk to turn off a computer. The chair slipped from underneath her and apparently struck her in the back, causing pain to the low back and injuring the knees and legs. Records indicate she had recently undergone carpal tunnel release. She sought care from ___, who instituted a conservative treatment protocol for the patient, but the patient has had minimal results from subjective pain. She is taking narcotic medication at this time for the treatment of her pain. Records from the requestor indicate a long standing history of emotional disturbance, dating back over 25 years. Records indicate that the patient was injured in ___ but has not responded at all to any conservative methods of treatment, nor to the medications provided.

REQUESTED SERVICE

The carrier has denied the medical necessity of a Chronic Pain Management Program for 30 days.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient has numerous problems in her emotional state that should be addressed by the treating doctor. ___ has appropriately referred this patient for treatment that would address the needs of a patient who has depression related to pain. While ___ has a long standing history of emotional disturbance, there is no doubt that she has difficulty dealing with her pain, or perception of such pain. All other care has generally failed, but now ___ is apparently dependent on narcotic medications. I believe a chronic pain program would be helpful for this patient and I feel that efforts to wean her from the medication would help her to return to a normal work life.

___ 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 14th day of April 2003.