

August 13, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1508-01

___ 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 the ___ external review panel. This physician is board certified in anesthesiology. The ___ 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, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 35 year-old female who sustained a work related injury on ___-. The patient reported that while at work she was a truck driver of a industrial vacuum used to clean up oil spills. The patient reported that on this date, she got too close to the vacuum and her right arm was sucked into the vacuum hose. The patient underwent an MRI and was diagnosed as having a torn cartilage in her right shoulder. The patient underwent surgery for repair of the torn cartilage. The patient reported that she experienced an exacerbation shortly after the surgery that caused pain in her injured shoulder. The patient has been treated with oral pain medications.

Requested Services

Chronic Pain Management Program times 30 sessions.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 35 year-old female who sustained a work related injury to her right arm, right shoulder and cervical spine on ___. The ___ physician reviewer also noted that the patient was diagnosed as having a cartilage tear of the right shoulder and underwent shoulder surgery. The ___ physician reviewer indicated that the patient reinjured her shoulder while lifting and has experienced continued right shoulder pain. The ___ physician reviewer also indicated that the patient has continued to complain of neck pain and was diagnosed with degenerative disc disease. The

___ physician reviewer noted that the patient has been under the care of a chiropractor and despite therapy has continued neck and shoulder pain. The ___ physician reviewer also noted that the patient has undergone a psychological evaluation that indicated the patient has a history of significant depression and post-traumatic stress disorder. The ___ physician reviewer further noted that the patient's treating chiropractor and therapist recommend a structured pain management program. The ___ physician reviewer explained that the patient has persistent shoulder pain status post surgery. The ___ physician reviewer also explained that the patient has not undergone a recent orthopedic re-evaluation or repeat imaging studies. The ___ physician reviewer indicated that there is no description of any radicular symptoms attributable to her cervical degenerative disc disease. The ___ physician reviewer explained that there is no documented failed treatment of other medication regimens indicating the need for a pain management program. The ___ physician reviewer also explained that there is no documentation indicating that the patient underwent a formal psychiatric evaluation for consideration of alternative medical regimens for the treatment of this patient's depression or post-traumatic stress disorder. Therefore, the ___ physician consultant concluded that the requested Chronic Pain Management Program times 30 sessions is not 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,

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 13th day of August 2003.