

September 11, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1573-01

___ 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. 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 62 year-old male who sustained a work related injury on ___. The patient reported that while at work he fell off a stool injuring his neck and shoulders. The patient underwent an MRI of the cervical spine on 4/4/01 and 6/2/03, an MRI of the shoulder on 6/2/03 and an EMG of the cervical spine and bilateral upper extremities. The diagnoses for this patient have included post right shoulder surgery, right shoulder derangement and cervical discogenic pain, bilateral cervical facet syndrome, and myofascial pain syndrome. The patient has been treated with epidural steroid injections, conservative care, medications and has undergone surgery in August of 2000 and another surgery in 2001. The patient has also participated in a pain management program.

Requested Services

30 days of chronic pain program.

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 62 year-old male who sustained a work related injury to his neck and shoulders on ____. The ___ physician reviewer also noted that the patient has undergone multiple diagnostic interventions including MRIs of the cervical spine and right shoulder and a total of surgeries involving his neck and right shoulder. The ___ physician reviewer indicated that the patient has also been treated with epidural steroid injections, nerve blocks, passive and active rehabilitation, physical therapy, biofeedback, individual therapy, group therapy and medical management. The ___ physician reviewer noted that the patient continues under the care of a pain management specialist and describes his pain as an 8/10 on a daily basis. The ___ physician reviewer explained that the documentation provided demonstrates that this patient suffers from a work related chronic pain condition. The ___ physician reviewer indicated that the diagnoses for this patient include post shoulder surgery syndrome, right shoulder derangement, cervical discogenic pain, bilateral cervical facet syndrome and myofascial pain syndrome. The ___ physician reviewer explained that this patient has exhausted all conservative and interventional treatment modalities for his condition. The ___ physician reviewer noted that the patient continues to require medication including Hydrocodone, Lortab and Soma. The ___ physician reviewer explained that this patient's pain syndrome has clearly adversely affected his quality of life and interfere with his sleep and his return to a full functional status. The ___ physician reviewer indicated that the patient has undergone a psychological evaluation that has determined this patient's case is a complex mix of emotional and medical conditions that would be best suited within an interdisciplinary environment. Therefore, the ___ physician consultant concluded that the 30 days of chronic pain program is 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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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 11th day of September 2003.