

August 7, 2003

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

MDR Tracking #: M2-03-1577-01
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.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. 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

This patient suffered a slip and fall injury on ___ while working in a ___. When she slipped on a wet floor in the rest room area and landed on her buttocks she felt immediate pain in her low back area. She was seen in the emergency room, examined and x-rays were taken, which were negative. Time passed and her symptoms continued. Her treatment program during that time is not clear.

Six weeks later on 10/8/02 she began initial chiropractic treatment with ___, but she did not progress well. This patient had an MRI, physical therapy modalities, EMG, passive and active chiropractic care, yet continued to exhibit very poor range of motion and continued with complaints of very high levels of pain. This pattern continued on into 2003. This patient was also found to have a considerable depression component.

An MRI of the lumbar spine dated 11/6/02 was unremarkable. On 1/22/03 she underwent a functional capacity evaluation. EMG/nerve conduction studies dated 1/23/03 were negative.

She underwent treatment at the ___ beginning 4/23/03 in a multiple day program. Her treatment was primarily for depression. In the spring of 2003 this patient showed marked improvement, according to the records progression, after beginning the psychological sessions.

REQUESTED SERVICE

A 30-day chronic pain management program is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

By 5/9/03 she was ready to return to a part-time position with restricted duty.

On the 7/23/03 office visit to ___ it was reported that the patient “came in today to be released to full duty. She is in no more pain in the area injured on ___.” “She is ready to return to full, non-restricted work at this time. She has no complaints of pain in the area of injury.” “We are releasing her to full, unrestricted duty.”

___ 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 7th day of August 2003.