

NOTICE OF INDEPENDENT REVIEW DECISION

November 10, 2003

RE: MDR Tracking #: M2-03-1721-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced 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, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in psychiatry which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians 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 this case.

Clinical History

This patient sustained a left shoulder injury on ___ when he stepped off the steps of his bus and fell, grabbing the door handle with his left hand. His left shoulder was pulled by the weight of his body and he reported feeling an immediate and sharp pain. He attended physical therapy. After a left shoulder MRI revealed bursitis and biceps tension tenosynovitis, he underwent arthroscopic surgery on 06/20/02. He had a second surgery to remove bone spurs and scar tissue. Other treatments include physical therapy, pain medications, and trigger point injections. He has been complaining of feeling depressed, irritated, and frustrated over his pain problems and not working.

Requested Service(s)

30 sessions of outpatient chronic pain multidisciplinary management services

Decision

It is determined that the proposed 30 sessions of outpatient chronic pain multidisciplinary management services are medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has had continuous pain for 17 months despite multiple surgical/medical treatments. He has been diagnosed as depressed by his treating physician and has scored high on psychological tests for depression and anxiety. By doing the recommended pain program, he can learn how his emotional and psychological issues are related to his pain and learn coping skills to deal with the chronic pain. The program should help him both with his pain and his depression issues. Therefore, it is determined that the proposed 30 sessions of outpatient chronic pain multidisciplinary management services are medically necessary.

This decision by the IRO 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for hearing and a **copy of this decision** must be sent to: Chief Clerk of Proceedings/Appeals Clerk, Texas Workers' Compensation Commission, P.O. Box 17787, Austin, Texas, 78744, Fax: 512-804-4011.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in this dispute.

Sincerely,

In accordance with Commission Rule 102.4 (h), 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 10 th day of November 2003.
