

October 28, 2003

Re: MDR #: M2-04-0146-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Physical Medicine & Rehabilitation.

Clinical History:

This male claimant sustained a torn right rotator cuff in a work-related accident on _____. He failed conservative therapy, including prolonged physical therapy, and underwent a right shoulder operation on 05/02/02. He re-entered physical therapy on 05/20/02, and completed that on 08/21/02. He has been noted to have re-injured this same shoulder on _____, and has been noted to have scored in a moderate-depression range on 08/06/03.

Disputed Services:

Chronic pain management program.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that a pain management program is not medically necessary in this case.

Rationale:

The patient has not had adequate rehabilitative treatment in the form of occupational therapy and/or physical therapy since his re-injury of _____. Prior to entering a chronic pain management program, this should be adequately addressed, as well as concomitant psychotherapeutic treatment for his depression (including medications).

A Functional Capacity Evaluation has not been performed since 09/17/02, at which time the patient was in a heavy work class for restricted work planes and in a medium work class for unrestricted vertical and horizontal planes. Until, and if, he fails a conservative course of treatment, a chronic pain management program is not appropriate.

I am the Secretary and General Counsel of _____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers

or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) 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.

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 October 28, 2003

Sincerely,