

December 22, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0531-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ 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 51 year-old male who sustained a work related injury on ___. The patient reported that while at work he slipped and fell on a wet floor landing on his right elbow, hip and ankle. Initial diagnoses for this patient have included contusion of hip, contusion of elbow, spasm of muscle, sprains and strains of ankle, right lateral epicondylitis and chronic bursitis. The patient has been treated conservatively with medications, anti-inflammatories, elbow brace, physical therapy and multiple injections including injections of the lateral condyle. The patient has also undergone a work hardening program and psychotherapy. Current diagnoses for this patient include adjustment disorder with depression and anxiety.

Requested Services

Chronic Pain Management Program times 20 sessions.

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 51 year-old male who sustained a work related injury to his right elbow, hip and ankle. The ___ physician reviewer indicated that this patient's diagnoses have included hip contusion, ankle sprain, right lateral epicondylitis and chronic bursitis. The ___ physician reviewer noted that treatment for this patient's condition has included oral medication, elbow brace, physical therapy, multiple injections of the epicondyle and a work hardening program.

The ___ physician reviewer explained that this patient has previously exhausted conservative and interventional therapies for pain management. The ___ physician reviewer indicated that in addition to this, the patient has developed an adjustment disorder with depression directly related to his chronic pain condition. The ___ physician reviewer noted that the documentation provided has demonstrated that the patient has shown improvement in his condition with the use of biofeedback and daily physical therapy. The ___ physician reviewer explained that the patient does require continued therapy to continue assistance in developing a specific return to work protocol. The ___ physician reviewer also explained that continued treatment with the pain management will maximize long-term success in the treatment of his chronic pain condition. Therefore, the ___ physician consultant concluded that the requested Chronic Pain Management Program times 20 sessions 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 22nd day of December 2003.