

NOTICE OF INDEPENDENT REVIEW DECISION

December 23, 2003

MDR Tracking #: M2-04-0546-01
IRO Certificate #: IRO4326

The ___ 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional 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 multiple injuries on ___ when she slipped on the edge of the sidewalk and fell. She underwent an open reduction and internal fixation (ORIF) of a right elbow fracture and radial head arthroplasty for a comminuted radial head fracture and radial collateral ligament tear. She also has had conservative treatment including medications, physical therapy, and chiropractic care.

Requested Service(s)

A chronic pain management program five times per week for six weeks

Decision

It is determined that the proposed chronic pain management program five times per week for six weeks is medically necessary to treat this patient's condition

Rationale/Basis for Decision

This patient underwent psychological testing which revealed a major depressive disorder and chronic pain directly associated with her on the job injury. Indicating she qualifies for a chronic pain management program.

Chiropractic guidelines allow for primary, secondary, and tertiary levels of care. Due to the multiple significant injuries this patient received, psychological testing, and the limited success she has obtained from her treatment to date, she qualifies for the tertiary level of care of a chronic pain management program. Therefore, it is determined that the proposed chronic pain management program five times per week for six weeks is 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,

<p>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 23rd day of December 2003.</p>
