

March 11, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0864-01

___ 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 36 year-old female who sustained a work related injury on ___. The patient reported that while at work she was unloading freight trucks and stocking shelves when she injured her neck and shoulder. The patient underwent an MRI of the left shoulder on 12/26/97 that showed mild degenerative changes involving the AC joint and a small amount of joint fluid. On 4/3/98 the patient underwent left distal clavicle resection and subacromial decompression. Following surgery the patient was treated with physical therapy. On 2/10/99 an MRI of the left shoulder showed post surgical changes in the area of the AC joint and distal clavicle. A MRI of the cervical spine dated 2/25/99 was reported as normal. An EMG dated 4/8/99 was reported as normal. The patient was then treated with physical therapy, massage therapy and an exercise program. The patient underwent facet injections on 1/17/03 and 10/1/03, and an injection to the forearm on 4/3/03. The patient has also been treated with Botox injections every three to six months. The diagnoses for this patient have included cervical radiculitis/neuritis, muscle spasm, headache, bursitis, subacromial/bursitis subdeltoid. Treatment for this patient's condition has included physical therapy, chiropractic adjustments, injections, medication management and shoulder surgery.

Requested Services

Chronic Behavioral Pain Management Program times 30 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 36 year-old female who sustained a work related injury to her neck and left shoulder on ____. The ___ physician reviewer indicated that the patient underwent evaluations that resulted in subacromial decompression on 4/3/98. The ___ physician reviewer noted that since the procedure on 4/3/98 the patient has been treated with physical therapy, massage therapy, chiropractic adjustments, medication management, exercise program facet injections and Botox injection. The ___ physician reviewer also noted that the diagnoses for this patient's condition has included cervical radiculitis/neuritis, muscle spasm, bursitis, and headache. The ___ physician reviewer further noted that in addition to this patient's pain from her injury, she has developed significant depression and anxiety and was recommended to attend a chronic behavioral pain management program. The ___ physician reviewer explained that there is a direct relationship between the enrollee's work related injury and her present chronic pain condition. The ___ physician reviewer indicated that the patient has been fully evaluated and received surgical therapy followed by multiple trials of conservative and interventional therapy without complete resolution of her pain. Therefore, the ___ physician consultant concluded that the requested Chronic Behavioral Pain Management Program times 30 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 11th day of March 2004.