

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** May 27, 2004

**RE: MDR Tracking #:** M2-04-1010-01

**IRO Certificate #:** 5242

\_\_\_ 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 Psychiatric reviewer (who is board certified in Psychiatry) who has an ADL certification. 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**

The claimant was injured on \_\_\_ in the context of a yanking injury while handling a large heavy pipe. Since that time he has been treated both conservatively and surgically for persistent pain in his right wrist. He apparently developed a probable complex regional pain syndrome of the right upper extremity and has had persistent pain. He was referred for a possible chronic pain management program by his primary treating physician, \_\_\_ recommended participation in a 30 day program. This request was denied with the rationale that the proposed services were not being supported by the medical information made available, this was appealed on 2/3/04 by \_\_\_; however, it was again denied for similar reasons on 2/5/04. His treating physician, \_\_\_, had also referred the claimant to \_\_\_. A note on 1/21/04 indicates there was a peer to peer with \_\_\_ of the \_\_\_. This peer-to-peer review resulted in a decision in favor of 2 additional stellate ganglion nerve blocks and recommendation for the non-authorization of the chronic pain management program by the \_\_\_. \_\_\_ notes are reviewed and indicate that during that time, he was recommending continued stellate ganglion nerve blocks, physical therapy, and pain medications to address the claimant's complex regional pain syndrome. He had discussed this course of progress with a peer who concurred with this course of action.

### **Requested Service(s)**

The medical necessity of 30 sessions of a chronic pain management program

### **Decision**

I agree with the insurance carrier that the services in dispute were not medically necessary at the time of denial.

**Rationale/Basis for Decision**

There does not appear to have been a coordinated treatment plan between \_\_\_\_, \_\_\_\_, and \_\_\_\_ during the time of denial of the chronic pain management program. Given that \_\_\_\_ was pursuing additional stellate ganglion blocks and that the carrier had approved these, it appears that the claimant had not exhausted all medically indicated primary and secondary levels of care which should occur prior to admittance into a tertiary level of care chronic pain management program. He may be appropriate for such a program after all primary and secondary levels of treatment have been employed and failed.

**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 a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
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 other party involved in this dispute.