

June 2, 2004

MDR #: M2-04-1253-01
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.

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.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is certified in the area of Chiropractic Medicine and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information from Requestor: correspondence, evaluation, treatment notes, pain management program notes, pre-authorization requests. *(It should be noted that the information from the Requestor was received after the case had been assigned to a reviewer and an initial report had been dictated. These records were provided to the reviewer for consideration.)*

Information from Respondent: correspondence.

Information from Treating Doctor: correspondence, office notes, EMG reports, operative reports, radiology reports and designated doctor exam.

Information from Surgeon: office notes, lab and radiology reports.

Clinical History:

The patient received extensive physical medicine treatments and underwent surgery as a result of injuring his right wrist at work on ___.

Disputed Services:

Behavioral chronic pain management program 5 X weekly, X 2 weeks (10 sessions).

Decision:

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

Rationale:

Although prior reviewers opined that the patient improved after the first 20 sessions of the chronic behavioral pain management program, the supplied medical records fail to document their opinions. Specifically, the patient obtained no significant relief from the treatment on the basis that his pain rating only decreased from 9 to 7-8 (when the stated goal was “3 to 4”), the treatment did not promote recovery on the basis that the Global Assessment of Functioning-GAF scores only improved from 57 to 63 (when the stated goal was 85), and the treatment did not enhance the employee’s ability to return to or retain employment. Since the proposed program has already been attempted and failed, it is highly unlikely that the patient would benefit in any meaningful way from repeating the same treatments.

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, MS-48
7551 Metro Center Dr., Ste. 100
Austin, TX 78744-1609

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 June 2, 2004

Sincerely,