

June 28, 2004

REVISED REPORT
Date of injury corrected in "Clinical History" section.

Re: Medical Dispute Resolution
MDR #: M2-04-1376-01
IRO Certificate #: 5055

Dear ____

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 ____ 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 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 provided by Requestor: letter of medical necessity, office notes, physical therapy notes, nerve conduction study, operative and radiology reports.

Information provided by Respondent: correspondence and designated doctor exams.

Clinical History:

The claimant was injured on the job on _____. She filed her claim in _____ and began treatment. She has since been treated conservatively through various means. Most recently, the patient has been treated with a 6-week chronic pain management program.

Disputed Services:

Behavioral pain management 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:

After reviewing the materials provided, the reviewer determined that the stated rationale being used to establish "medical necessity in the case" for the services requested is not adequate to justify the program desired. Two points in particular failed to be answered:

- (1) The requestor has not given any information explaining why the requested 2 weeks will result in any further improvement in this patient's condition. Stating that the "patient is still experiencing some anxiety and is very reluctant on lifting because she is afraid she will re-injure herself" is fine. However, although stating that "it would be beneficial to her to have her anxiety decreased", the requestor gives no information as to how that will be addressed differently in the next 2 weeks of the program as opposed to the previous 6 weeks of the program.
- (2) The requestor states, "This patient needs further education on lifting and encouragement in performing it. She needs more direction in this area." It is not stated what further education on lifting and what more direction in this area this patient can be given in the next 2 weeks that she has not already received. With these questions being left unanswered, there is no rationale given that this patient will have any additional benefits from an additional 2 weeks of a chronic pain management program.

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 23, 2004.

Sincerely,