NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-1495-01
IRO Certificate Number: 5259

July 21, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

Sincerely,

CLINICAL HISTORY

The records in this case reflect that the patient was employed in a custodial position apparently with ___ on the date of injury. She was a 49-year-old female who tripped over stone and fell injuring her right knee. She had subsequent arthroscopic procedure to her right knee and had medial and lateral meniscus pain. She continued to work and continued to receive treatment and continued to report complaints of pain. She has been seeing orthopedic surgeon, ___. His most recent note provided of 05/10/04 indicates there is still swelling and locking

to her knee and he recommends repeat arthroscopy. There is request from ___ in ___ for psychiatric testing and chronic pain management program. Also, there is a documented request for individual biofeedback sessions for pain control.

REQUESTED SERVICE(S)
Medical necessity of proposed psychological testing.

DECISION
Denied.

RATIONALE/BASIS FOR DECISION
Psychological testing is not reasonable, appropriate, or necessary at this point in time. Decision is made based on the fact that this individual has a fairly acute injury occurring on ___ with subsequent surgical treatment on 10/24/03. Postoperatively, she continues to have complaints of knee pain and her surgeon feels that there is need for possible repeat arthroscopy of the knee and the patient is willing to proceed with that procedure. Pain management program and assessment for pain management program are processes for individuals that have completed all treatment and have no hope of improving. In this particular case, there is clear cut ongoing evidence of mechanical dysfunction to the knee and the patient and her physician feel that treatment management of the underlying dysfunction of the knee are appropriate and will likely give her improvement. Therefore, pain management which is a last effort of treatment when there is no correctable underlying functional derangement indicated. This rationale is based on standards of care for treating chronic pain, Worker's Compensation injuries. Support through chronic pain management is utilized if there is no correctable physiologic or anatomic derangement that can be repaired that will reduce the pain. At this point in time, there still appears to be a physiologic abnormality and derangement that would respond to additional treatment.

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 (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a 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

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

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 22nd day of July 2004.