

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-2405.M2

October 15, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-0052-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
----- Case #:**

----- 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 and is familiar with the condition and treatment options at issue in this appeal. 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 49 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his right wrist and hand when he attempted to lift a 40-foot joist. The patient was initially evaluated by x-rays and prescribed medications and returned to work. An X-ray performed on 6/11/03 indicated a possible sprain or ligamentous injury of the right wrist. The patient reportedly underwent an MRI and was further treated with injections. The patient subsequently underwent hand surgery. Following surgery the patient participated in a work hardening/conditioning program. The current diagnoses for this patient include post-op C.T.S., right wrist, sprain/strain, right wrist, and joint pain. The patient has been recommended for a chronic pain management program for further treatment of his condition.

Requested Services

Chronic Pain Management Program times 30 sessions.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Assessment 8/6/04
2. Letter of medical necessity 8/9/04
3. Treatment Plan Review/Treatment Plan and Goals 8/9/04
4. Chart Notes 5/26/04 - 7/28/04
5. X-ray report 6/11/03
1. WH/WC Daily Progress Notes 6/25/04 – 7/16/04

Documents Submitted by Respondent:

1. No documents submitted.

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 49 year-old male who sustained a work related injury to his right wrist on ----- . The ----- physician reviewer indicated that the patient had been treated with injections and surgery. The ----- physician reviewer noted that the current diagnoses for this patient include postoperative carpal tunnel syndrome, chronic sprain/strain, and joint pain. The ----- physician reviewer also noted that the patient had completed a work hardening program and has been recommended to attend a chronic pain management program. The ----- physician reviewer explained that the patient has a work related chronic pain condition and has been fully evaluated. The ----- physician reviewer explained that the patient had undergone surgery without resolution of ongoing pain. The ----- physician reviewer also indicated that the patient has evidence of depression and anxiety directly relation to his pain condition. The ----- physician reviewer explained that the patient has tried and failed primary and secondary levels of treatment and that a chronic pain management program including behavioral and cognitive interventions is indicated at the time. The ----- physician reviewer also explained that the patient would benefit from a full multidisciplinary program including psychotherapy, group therapy, nutrition education, relaxation, social skills training and physical activity. Therefore, the ----- physician consultant concluded that the requested chronic 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,

State Appeals Department

cc: Texas Workers Compensation Commission

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 15th day of October 2004.

Signature of IRO Employee

Name