

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0659-01
Name of Patient:	
Name of URA/Payer:	City of San Antonio
Name of Provider: (ER, Hospital, or Other Facility)	Positive Pain Management
Name of Physician: (Treating or Requesting)	Paul Pace, MD

April 13, 2005

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

Medical Review of Texas (MRT) 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 MRT.

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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Positive Pain Management
Paul Pace, MD
Texas Workers Compensation Commission

CLINICAL HISTORY

The records reflect that Ms. ____ was employed with the city of San Antonio. She is a 28-year-old female who began having complaints of flexor tendonitis in both hands. She had electrodiagnostic studies which failed to reveal any significant abnormalities. She had been under the care of Dr. Pace. She had a documented physical exam by Michael Jones, M.D., a second opinion physician, showing negative Phalen's, negative Tinel's, negative CMC grind test, negative Watson's maneuver, and negative resisted flexion test. This evaluation was performed on May 13, 2004. There are also records reviewed from Dr. Paul Pace indicating that MRI was done on the neck and was perfectly normal. EMGs were performed of the upper extremities and were normal.

By January 26, 2005, the patient was seen in Dr. Pace's office, noted to have resolving carpal tunnel and right pronator tunnel syndrome. He would like to inject the right pronator tunnel syndrome with dexamethasone, referred to therapy, and will coordinate with employer to get an ergonomic split keyboard and will continue prevention program and see her back in two or three months. He indicates that she was doing much better making good progress with her hands and responded well to conservative techniques. Several months prior to that, he had requested a referral to a massage therapist and also to pain management, Positive Pain Program, requested services pain management program, comprehensive multidisciplinary decision.

REQUESTED SERVICE(S)

Medical necessity of proposed chronic pain management x30 days.

DECISION

Denied. There is no clinical information to support a chronic pain management program as a direct result of a work injury.

RATIONALE/BASIS FOR DECISION

Basis for the decision is multifocal, but includes the fact that there is no clinical diagnostic evidence for carpal tunnel syndrome. At least two different physicians other than the treating physician who

evaluated this patient diagnosed evidence of tenosynovitis, no abnormalities on EMG, and no evidence of Tinel's or Phalen's sign. Good response to conservative care as documented in the treating physician's notes and was basically referred to return to work with ergonomic keyboard on January 26, 2005, indicating that there is no necessity for services including pain management program.

Furthermore, the specific diagnosis is in question, and there is agreement with carrier's response that additional diagnostic testing may be appropriate to determine the true cause of her symptoms and whether they really are related to work activity or underlying arthritide. Finally, the patient's own physician indicates she no longer needs positive pain management as she is trying to work with ergonomic keyboard.

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 18th day of April, 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell