

May 16, 2005

**Re: MDR #:** M2-05-1396-01 **Injured Employee:**  
**TWCC#:** **DOI:**  
**IRO Cert. #:** 5055 **SS#:**

**TRANSMITTED VIA FAX TO:**

**Texas Workers' Compensation Commission**

Attention:  
Medical Dispute Resolution  
Fax: (512) 804-4868

**RESPONDENT:**

City of San Antonio  
Attention: Brandi Prejean  
(512) 346-2539

**TREATING DOCTOR:**

Joseph J. Floyd, DC  
(210) 921-0398

Dear Mr. \_\_\_\_:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI 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 Independent Review, Inc. 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 board certified in Neurology and Pain Management and is currently listed on the TWCC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. 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 May 16, 2005.

Sincerely,

Gilbert Prud'homme  
General Counsel

GP/th

**REVIEWER'S REPORT  
M2-05-1396-01**

**Information Provided for Review:**

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

Information provided by Respondent:

Correspondence

Case reviews and evaluations

Information provided by Treating Doctor:

Correspondence

Psychiatric evaluation 01/27/05

PPE 02/03/05

Information provided by Orthopedic Surgeon:

Initial consultation and office notes 12/16/04 - 01/19/05

**Clinical History:**

This female claimant suffered a work-related knee injury on \_\_\_\_\_. After failing conservative therapy, she had knee surgery that failed to fully relieve her pain or restore full function.

**Disputed Services:**

Thirty (30) sessions of chronic pain management.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that 30 sessions of a pain management program are medically necessary in this case.

**Rationale:**

A chronic pain management program is well-supported by the facts of the case, as well as the psychiatric assessment. The patient had an active and vocationally productive lifestyle prior to her accident. She now has to adjust to having chronic pain and some functional impairment.

The patient would benefit from a pain management program in several ways. Hopefully, by coming to terms with her chronic pain and functional impairment, she will decrease her stress and depression, thereby decreasing her pain and improving her quality of life. In turn, this will allow her to enjoy maximal functional abilities and quality of life.