

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0974-01
Name of Patient:	
Name of URA/Payer:	Ace American Insurance Co.
Name of Provider: (ER, Hospital, or Other Facility)	Bexar County Healthcare Systems
Name of Physician: (Treating or Requesting)	Douglas Burke, DC

March 9, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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.

March 9, 2005
Notice of Independent Review Determination
Page 2

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Bexar County Healthcare Systems
Douglas Burke, DC
Texas Workers Compensation Commission

RE:

CLINICAL HISTORY

Available documentation received and included for review consists of records from multiple providers including Drs. Stephenson (MD) Barrett (DPM) Olin (MD), Ganc (MD), Bieler (MD) Shay (MD), Outlaw (DC) Zarzuela (DO) and Erredge (DPM).

Record review reveals the following:

____, a 52 -year-old male, injured his left foot and ankle when it was run over by a forklift on _____. Initial impressions were contusion, possible fracture and ankle sprain/strain. Diagnosis later included crush injury with fifth toe fracture, and tenosynovitis to the dorsum of the foot extensor tendons. Initial treatment involved immobilization along with medications and some therapy through Dr. Outlaw, (chiropractor). Dr. Barrett, (podiatrist) then injected some steroids into the ankle joint. MRI's were obtained and revealed an osteochondral dome lesion to the posterior medial talus of the left foot with a tear of the anterior talofibular ligaments and extensive tenosynovitis. The patient went to surgery with Dr. Barrett on 8/6/03 to repair the dome lesion, debride necrotic cartilage and bone along with repair of the anterior talofibular ligament. This was followed with post surgical rehab with Dr. Outlaw. A psychiatric evaluation was performed on 9/29/03 and identified adjustment disorder with mixed anxiety and depression along with chronic pain. Chronic pain management treatment was recommended. A pain management evaluation was performed on 11/10/03 and CRPS of the left lower extremity was assessed, along with left ankle internal derangement

syndrome, status post surgery. Lumbar sympathetic blocks were recommended and performed December 2003, January and February 2004. Chronic pain management program was recommended following a behavioral health evaluation on 3/29/04. Spinal cord stimulator implant was recommended by Dr. Shay, and surgery was performed 7/14/04. A subsequent psychological evaluation on 8/9/04 recommended chronic pain program. The patient was evaluated for designated doctor purposes on 1/10/05 and found to be of MMI with a 16% whole person impairment. The designated doctor felt that further treatment may be necessary in the form of neurolysis of the tarsal tunnel, deep peroneal superficial peroneal and sural nerves. She believed the examinee had RSD.

REQUESTED SERVICE(S)

Prospective medical necessity chronic pain management program five times per week for 2 weeks.

DECISION

Approved. Medical necessity is established for a chronic pain management program.

RATIONALE/BASIS FOR DECISION

A chronic pain program involves a multidisciplinary approach and is reserved typically for outliers of the normal patient population, i.e. poor responders to conventional treatment intervention, with significant psychosocial issues and extensive absence from work^(1,2).

Chronic pain or chronic pain behavior is defined as devastating and recalcitrant pain with major psychosocial consequences. It is self sustaining, self regenerating and self-reinforcing and is destructive in its own right as opposed to simply being a symptom of an underlying somatic injury. Chronic pain patient's display marked pain perception and maladaptive pain behavior with deterioration of coping mechanisms and resultant functional capacity limitations. The patients frequently demonstrate medical, social and economic consequences such as despair, social alienation, job loss, isolation and suicidal thoughts. Treatment history is generally characterized by excessive use of medications, prolonged use of passive therapy modalities and

unwise surgical interventions. There is usually inappropriate rationalization, attention seeking and financial gain appreciation⁽²⁾.

This patient clearly appears to satisfy all above requirements. Multiple providers have recommended this course of care. The results of the psychological assessments tend to indicate that he would not perform well in a work hardening environment. The psychological assessments identified maladaptive coping styles that would be best addressed in a behavioral chronic pain program.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

1/ CARF Manual for Accrediting Work Hardening Programs

2/ AMA Guides to the Evaluation of Physical Impairment, 4th Edition

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).

March 9, 2005
Notice of Independent Review Determination
Page 5

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 9th day of March 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell