

# 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:	M2-05-1823-01
Name of Patient:	
Name of URA/Payer:	Travelers
Name of Provider: (ER, Hospital, or Other Facility)	Valley Total Healthcare Systems
Name of Physician: (Treating or Requesting)	Ruben Pechero, MD

June 28, 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.

June 28, 2005  
Notice of Independent Review Determination  
Page 2

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Valley Total Healthcare Systems  
Ruben Pechero, MD  
Texas Workers Compensation Commission

CLINICAL HISTORY

This is a 5'4" 180 pound lady who reportedly sustained an injury on or about \_\_\_\_\_. In January 2004, an MRI of the lumbar spine was completed and this study noted a three year history of a prior lumbar surgery. The surgery apparently took place two years prior to the date of injury. Subsequent to that MRI another lumbar fusion surgery is undertaken. Subsequent to that procedure a number of rehabilitation attempts have been made, as noted by Dr. Pechero. By May 19, 2005, she had been able to return to work. A retraining program via the Texas Rehab Commission was completed. Additionally a work hardening program was completed.

REQUESTED SERVICE(S)

Chronic Pain Management Program

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This is a lady who underwent a fusion procedure, and there is a possibility that this was done twice, who is severely deconditioned and has not made any progress from any perspective whatsoever. Thus, the question becomes, is this reasonable and necessary care and is there a reasonable chance for success? To answer the later question, there is no chance for success. This lady has undergone half of what would be attempted in the Chronic Pain program in the work conditioning program. No functional gains were made and in the time ensuring from the date of surgery there was no improvement in terms

of weight loss or other functional abilities. Thus, one does not see any gains whatsoever from this requires.

The second issue resides with the lack of lower levels of care. It would appear that the primary treating physician simply went for the highest level without consideration of the relative efficacy. Sending someone to a work hardening program when the employer could not institute the work restrictions would be a needless waste of time and effort.

Third, the nationally published guides for such a request each would not meet the requirements noted in this case. This lady has not done anything for herself, has not responded to any of the care rendered, has not undergone lower level of care and fails to meet the criteria from several national publications. One does not see allowing this apparent fruitless endeavor from going forward.

#### REFERENCES:

Official Disability Guidelines  
Millerman & Roberts  
ACOEM

## 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 30<sup>th</sup> day of June 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell