

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0655-01
Name of Patient:	
Name of URA/Payer:	City of San Antonio
Name of Provider: (ER, Hospital, or Other Facility)	Bexar County Healthcare System
Name of Physician: (Treating or Requesting)	Dennis Gutzman, MD

March 6, 2006

An independent review of the above-referenced case has been completed by a medical physician board certified in neurology. 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 the Division of Workers' Compensation 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.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Bexar County Healthcare System  
Dennis Gutzman, MD  
Division of Workers' Compensation

#### CLINICAL HISTORY

Records reviewed included: Argus Services Corporation preauthorization report and notification of 12/6/05 and 11/28/05; Bexar County Healthcare Systems request for pain management 11/10/05; letter from Harrison Harris Attorneys at Law 2/2006; request for an appeal from Bexar County Healthcare Systems 11/25/05; Bexar County Healthcare evaluation of 10/26/05; initial evaluation of Khym Zarzuela, DO of 10/27/05; various therapy evaluations of Mr. \_\_\_ at Advantage Healthcare Systems and Bexar County Healthcare; various office visits of Mr. \_\_\_ to Dr. Gutzman; report of MRI lumbar spine dated 6/8/1998; report of lumbar spine AP and lateral 6/30/1998; report of contrast enhanced CT of lumbar spine 6/30/1998; report of left L4 foraminotomy, left L5 foraminotomy 6/17/02; various other reports from Bexar County Healthcare Systems.

Mr. \_\_\_ was employed by the City of San Antonio as a truck driver/laborer and reportedly injured his low back on the job at 47 years of age. He, over the years, required seven (7) low back surgeries and continued to have severe low back pain. Treatments have included multiple passive modalities, physical therapy, the seven surgeries, chiropractic adjustments, and multiple medications.

#### REQUESTED SERVICE(S)

Pain management program x 10 sessions.

#### DECISION

Approved.

#### RATIONALE/BASIS FOR DECISION

Chronic pain management is not a program for depression which is a frequent misunderstanding. Chronic pain management programs are comprised of multidisciplinary approaches to treat both pain and the

psychological effects of the pain. Psychological effects of pain include depression but are not solely limited there to. Patients with chronic pain need education which is provided from the therapist as well as psychotherapist. Patients with chronic pain need coping techniques which are not provided in any other format other than behavioral based pain management programs. Without coping techniques for chronic pain and without the education, these patients are doomed to failure. Straightforward work hardening can certainly be appropriate after an acute or subacute injury; however, after this length of time a work hardening program is totally insufficient. Ten sessions of a comprehensively based multidisciplinary pain program is extremely important for a patient in a position such as Mr. \_\_\_\_'s. The education, counseling and coping techniques must be in conjunction with the physical therapy for success.

#### Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

## YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings  
Division of Workers' Compensation  
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 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 8<sup>th</sup> day of March, 2006.

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

Printed Name of IRO Employee: Cindy Mitchell