

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0798-01
Name of Patient:	
Name of URA/Payer:	Zurich American Insurance
Name of Provider: (ER, Hospital, or Other Facility)	Behavioral Healthcare Assoc.
Name of Physician: (Treating or Requesting)	Louis Zegarelli, MD

April 3, 2006

An independent review of the above-referenced case has been completed by a medical physician board certified in family practice. 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: Behavioral Healthcare Assoc.  
Louis Zegarelli, MD  
Division of Workers' Compensation

### CLINICAL HISTORY

Records submitted for review:

- Denial letters from Zurich Service Corporation;
- Documents from Workers' Compensation Department;
- A PPE on 4/14/05;
- BHCA position letter dated 9/25/05;
- Health & Behavior Assessment dated 3/17/05;
- Psychological Treatment Summary and Service Request dated 6/29/05;
- Health & Behavior Assessment Addendum dated 5/23/05;
- Counseling session note from Bob Grant, Ph.D. dated 6/30/04;
- Clinical notes from Dr. Zegarelli;
- Attorney letters from Scott Bouton and Greg Solcher;
- Electromyography report dated 11/26/02; and
- Peer Review – Dr. Smith – dated 2/24/05.

Patient had a work related injury \_\_\_\_\_. She was treated with medications, trigger point injections, cervical epidural injections, massage, physical therapy, muscle stimulator, heat, ice, acupuncture, and biofeedback. She had cervical fusion in 1997 and a bread reduction in 2003. Apparently, she had right sided shoulder arthroscopy and decompression of the median nerve but it is unclear from the submitted documents if these procedures were as a result of the compensable injury on \_\_\_\_\_. She has continued to have pain and has been diagnosed with chronic pain and failed neck syndrome.

### REQUESTED SERVICE(S)

Pain Management Program; 8 hours a day for 5 days for 6 weeks.

### DECISION

Denied.

### RATIONALE/BASIS FOR DECISION

The documentation submitted does not support the medical necessity of the program requested for this patient. Generally accepted guidelines, literature, and standard of care dictate a patient must have a reasonable chance of significant and lasting results from treatment.

Unfortunately, this patient does not fulfill the criteria for several reasons. First, her original injury was in \_\_\_\_ with subsequent surgeries in 1997 and 2003. No literature found supports the use of a chronic pain program 14 years out from the original injury of 9 years out from cervical fusion or 3 years out from breast reduction surgery. Second, no literature found proves improved outcomes from a multidisciplinary pain program when a patient has failed to respond to every therapy in the program when same treatment was rendered in a multimodality scenario. The patient has had psychiatric/psychological evaluation and treatment as well as biofeedback, physical therapy, medication management, etc. She continued to have symptoms although every modality used in a chronic program had been tried independently.

Also, Dr. Smith noted "...this claimant has been through multiple pain management programs that did not seem to benefit her, so I doubt if any further benefit would come from pain management, especially this far out from the \_\_\_\_ original date of injury." This patient may benefit from vocational training/rehab, more intensive psychiatric evaluation and treatment, and long term medication management but the submitted documentation does not support the medical necessity of a multidisciplinary pain program for this patient.

### References:

\*Evidence-Based Clinical Practice Guidelines for Interdisciplinary Rehabilitation of Chronic Nonmalignant Pain Syndrome Patients by Sanders, *Pain Practice*, Dec. 2005.

\*American Society of Anesthesiologists Task Force on Pain Management.

\*Efficacy of Multidisciplinary Pain Treatment Centers by Flor, *Pain*

\*ACOEM Guidelines

\*National Guideline Clearinghouse

\*Texas Labor Code 408.021

### 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 3<sup>rd</sup> day of April 2006.

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

Printed Name of IRO Employee: Cindy Mitchell