

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0825-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance
Name of Provider: (ER, Hospital, or Other Facility)	Bexar County Healthcare Systems
Name of Physician: (Treating or Requesting)	Lawrence Lenderman, MD

March 30, 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.

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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Bexar County Healthcare Systems
Lawrence Lenderman, MD
Division of Workers' Compensation

CLINICAL HISTORY

Records submitted for review include: notification of IRO assignment; progress notes from Lawrence Lenderman, MD; lumbar spine CT scan after discography, Sendero Imaging 3/10/05; lumbar discogram report, Dennis Karasek, MD 3/10/05; operative report by Lawrence L. Lenderman, MD 8/30/05; cross table lateral lumbar spine 8/30/05, path report lumbar disc tissue 8/30/05; diagnostic interview and treatment plan Bexar County Healthcare Systems 11/4/05; evaluation by Kahym Zarzuela, DO 11/22/05; request for pain management program 10 sessions 12/9/05; request for appeal of pain management program 12/31/05; records from Texas Mutual Insurance 3/16/06.

The patient reported that in ____, when 44 years old and on the job, he fell off a tree injuring his low back primarily. Continuous low back and right leg pain since that time. Treatment with epidural steroid injections and physical therapy without benefit. Pain had become, by February 2005, "incapacitating." Underwent lumbar discography March 2005. Underwent L4-5 laminotomy, foraminotomy, and lateral fusion with L5-S1 laminectomy, discectomy, foraminotomy, and lateral fusion and L4 to S1 posterior spinal instrumentation 8/30/05. Apparently no improvement in pain.

REQUESTED SERVICE(S)

Chronic pain management program for 10 sessions.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

Documentation for approval has already been recorded. See State Office of Administrative Hearings docket numbers as reported and appeal request of Bexar County Healthcare Systems dated 12/31/05. This patient is obviously in need of extensive education to convert his conceptualization of pain from an acute to a chronic paradigm. This will be done no place other than a chronic pain management program. The patient also needs the physical therapy modalities, cognitive behavioral therapy, pain management training, instruction, and coping therapies other than pain medication. A pain management program is obviously the best treatment for this patient at this point.

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 31st day of March 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell