

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

| | |
|--|------------------------------|
| TDI-WC Case Number: | |
| MDR Tracking Number: | M2-06-1154-01 |
| Name of Patient: | |
| Name of URA/Payer: | Twin City Fire Insurance Co. |
| Name of Provider: (ER, Hospital, or Other Facility) | |
| Name of Physician: (Treating or Requesting) | C.M. Schade, MD, PhD |

May 31, 2006

An independent review of the above-referenced case has been completed by a 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 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: _____
C.M. Schade, M.D., PhD
Division of Workers' Compensation

CLINICAL HISTORY

Documents submitted for review:

1. The Hartford Insurance Review
2. Dr. John Tsu-Yuan Wey operation notes
3. Health View notes
4. Central Rehab notes
5. FCE-M.D. Rehab of Texas
6. TWCC 5/2/05
7. Designated doctor evaluation
8. Orthopaedic Associate notes
9. Center for Pain Control-C.M. Schade, M.D., PhD
10. Vista Hospital Summary

This is a 41-year old male with a 27+ month history of left leg and ankle pain since a ____ work-related accident. He has had surgical and conservative treatments.

REQUESTED SERVICE(S)

Chronic pain management-20 sessions.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

This patient is an ideal candidate for an interdisciplinary rehabilitation pain program. In fact, this is the typical patient that Dr. J. Rome treats in his program at the Mayo Clinic [Rome, J., Mayo Clinic Proceedings-articles] and evidence-based clinical guidelines for interdisciplinary rehabilitation of chronic non-malignant pain syndrome patients [Pain Practice 5(4), 303-315].

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 1st day of June 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Marc Salvato