

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

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## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-1533-01
Name of Patient: _____	
Name of URA/Payer:	Hartford Underwriters, Inc.
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dean McMillan, MD

July 26, 2006

An independent review of the above-referenced case has been completed by a 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:  
Dean R. McMillan, MD  
Division of Workers' Compensation

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#### DOCUMENTS REVIEWED

Notification of IRO assignment; documentation of medical necessity for CPMP from Dr. McMillan dated 2/15/06; independent review from designated doctor 4/4/ to 10/11/05; Village Fire Department, Houston, Texas, initial medical response 11/19/04; multiple records from Greater Houston Orthopedic Specialist; operative report Memorial Hermann Northwest Hospital open reduction and internal fixation, right distal tibial fracture 11/20/04, surgeon Adam Klein, MD; operative report River Oaks Surgical Center 1/7/05 irrigation and debridement of right ankle wound with closure, surgeon David Bloome, MD; multiple records from Pain and Recovery Clinic of North Houston operative report 5/23/05, Northwest Surgery Center Houston, Texas, removal of screws one, two, three, and four, surgeon Lubor J. Jarolinmek, MD.

#### CLINICAL HISTORY

A 63-year-old male who fractured his right distal tibia while at work \_\_\_\_\_. Pain reported at 10/10 immediately. He underwent open reduction with internal fixation on the fractured distal right tibia on 11/20/04. Physical therapy was initiated with which the patient was compliant. The pain continued. There was diffuse osteopenia of the right foot with restricted range of motion. On 5/23/05 the patient underwent removal of the screws of the right distal tibia. The patient then underwent 90 sessions of further physical therapy. The patient was diagnosed in a mental health evaluation done November 2005 as having an adjustment disorder, depression, and pain disorder. A comprehensive chronic pain management program was recommended. This was approved by the independent review of 4/4/05 – 10/11/05 but for only ten sessions and then reevaluation.

#### REQUESTED SERVICE(S)

Chronic pain management program - 20 sessions (97799-CP).

#### DECISION

Approved.

#### RATIONALE/BASIS FOR DECISION

Mr. \_\_\_\_ sustained a compensable work injury which has resulted in chronic pain and chronic functional limitations. He has exhausted

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other levels of treatment including surgery and multiple standard physical therapy treatments. He has a high average level of chronic pain. Mr. \_\_\_ obviously needs to learn alternative methods of pain other than dependence upon analgesic medication. His adjustment disease with mixed anxiety and depressed mood and pain disorder are entirely consistent with his chronic pain and would be best treated in the chronic pain management program. He can continue psychotherapy sessions as well in the chronic pain management program. Per the TWCC spine treatment guidelines rule 134.600 chronic pain management is the proper treatment and intervention for patients with conditions in the tertiary level of care such as Mr. \_\_\_'s. The chronic pain management program has already been approved in the independent review. Ten sessions of treatment are not a sufficient duration of treatment. A pain management program, by its nature, includes a significant amount of education with lots of repetition. This would take at least 20 treatment sessions. This is approved.

#### 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 27<sup>th</sup> day of July, 2006.

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

Printed Name of IRO Employee: Cindy Mitchell