


INDEPENDENT REVIEW INCORPORATED

January 9, 2007

Amended January 10, 2007

Re: MDR #: M2 07 0534 01 Injured Employee: _____
DWC #: _____ DOI: September ____ 2005
IRO Cert. #: 5055

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: Liberty Mutual

REQUESTOR: Ft. Worth Healthcare Systems

TREATING DOCTOR: Irme Kocsis, DO

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him 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 Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is a board certified in anesthesiology and pain management and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to all participating parties and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

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.

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 January 9, 2007.

Sincerely,

jc

Jeff Cunningham, DC
Office Manager



REVIEWER'S REPORT M2 07 0534 01

MEDICAL INFORMATION REVIEWED:

1. Workers' Compensation assignment documentation
2. Carrier's records
3. Requestor's records including physical performance examination and evaluation dated 09/06/06

BRIEF CLINICAL HISTORY:

The patient is a 44-year-old female with an apparent work-related injury on 09/___/05 to the right knee, hip, lumbar, and cervical spine. The patient has been treated with facet injections, shoulder arthroscopy, and radiofrequency rhizotomies. Conservative treatment measures have included biofeedback and physical therapy. The patient is presently treated with narcotic analgesics. There is a previous history of treatment for depression. The patient presently presents with a chronic pain syndrome involving the lumbar spine and the right lower extremity.

DISPUTED SERVICES:

Chronic behavioral pain management program times 10 sessions.

DECISION:

I DISAGREE WITH THE ADVERSE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

RATIONALE OR BASIS FOR DECISION:

The patient in this case needs reasonable criteria for the diagnosis of a chronic pain syndrome. The pain has persisted beyond 6 months, it is out of proportion to any explained pathophysiology, has not responded to appropriate treatment, and has impaired the patient's function. Chronic pain management programs in this setting are an accepted treatment if they set forth specific patient goals and interventions. Ms. _____ letter of 10/09/06 and evaluation of 09/06/06 accomplish this requirement; the goals are set forth. The previous history of depression and present lack of antidepressant medication could impact the success of the program, but the patient remains a candidate for the program.

SCREENING CRITERIA/TREATMENT GUIDELINES/ PUBLICATIONS UTILIZED:

The guidelines for the treatment of a chronic pain syndrome in this setting are set forth in the "Evidence-based Clinical Practice Guidelines for Interdisciplinary Rehabilitation of Chronic Nonmalignant Pain Syndrome Patients." This is available at the National Guideline Clearinghouse website (www.guideline.gov). These guidelines are taken from Sanders, et al, Siskin Hospital for Physical Rehabilitation, published 2005, page 41, which is an update of the same guidelines referenced by Ms. _____ in her letter of 10/06/06.