


INDEPENDENT REVIEW INCORPORATED

November 15, 2006

Re: MDR #: M2 07 0138 01 Injured Employee: ___
DWC #: ___ DOI: ___
IRO Cert. #: 5055 SS#: ___

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: ___

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT: Hartford

REQUESTOR: Ft. Worth County Healthcare

TREATING DOCTOR: Chris Pratt, 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 with additional qualifications in pain medicine and is currently listed on the DWC Approved Doctor List.

**P.O. Box 855
Sulphur Springs, TX 75483
903.488.2329 * 903.642.0064 (fax)**

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 November 15, 2006.

Sincerely,

jc

Jeff Cunningham, DC
Office Manager

**REVIEWER'S REPORT
M2 07 0138 01**

MEDICAL INFORMATION REVIEWED:

1. Workers' Compensation assignment
2. Requestor's records including office visits, evaluations, radiologic reports dated 07/03 through 09/06.

BRIEF CLINICAL HISTORY:

The patient is a 53-year-old female who suffered an apparent work-related injury on ___ involving the upper and lower back. The patient has been extensively managed with conservative treatment including physical therapy, rehabilitation, facet blocks, analgesics, antidepressants, and anxiolytics. Studies have not revealed a treatable physical diagnosis, although recent MRI scans are not available.

DISPUTED SERVICES:

Chronic pain management program times 10 sessions.

DECISION:

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

RATIONALE OR BASIS FOR DECISION:

The patient has a chronic pain syndrome by any reasonable definition. For maximum efficacy, multidisciplinary chronic pain program rehabilitation requires well-defined individualized treatment goals and treatment plans. Given the longevity and chronicity of this patient's pain, the prognosis would be poor but not predetermined.

SCREENING CRITERIA/TREATMENT GUIDELINES/ PUBLICATIONS UTILIZED:

The most applicable screening criteria in this case is the American College of Occupational and Environmental Medicine. For reference, see Occupational Medicine Practice Guidelines, 2004. Additionally of help here is the evidence-based Guidelines for Interdisciplinary Rehabilitation of Chronic Nonmalignant Pain Syndrome Patients by Sanders, et al, Siskin Hospital for Rehabilitation 2005.