

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Phone: 512-288-3300

Austin, Texas 78735

FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-07-0322-01
Name of Patient:	
Name of URA/Payer:	Liberty Insurance Corp.
Name of Provider: (ER, Hospital, or Other Facility)	North Texas Pain Recovery Center
Name of Physician: (Treating or Requesting)	Susan Linder, MD

December 11, 2006

An independent review of the above-referenced case has been completed by a physician board certified in family practice. 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.

December 11, 2006
Notice of Independent Review Determination
Page 2

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
North Texas Pain Recovery Center
Susan Linder, MD
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

Records submitted for review included:

- Clinical notes from Dr. Burroughs;
- Letter from Liberty Mutual concerning the original denial and subsequent denial of the appeal;
- Letter from Dr. Henderson of Intracorp;
- Clinical notes and letters from North Texas Pain Recovery Center by various providers; and
- Brain MRI dated 11/14/05.

CLINICAL HISTORY

Mr. ____ was hit in the head by a pipe on _____. He was treated with rest, medication, physical therapy, and biofeedback. He underwent psychological counseling as well. At one point he was admitted to the hospital for severe headaches and GI distress secondary to NSAIDS. A request was made for a multidisciplinary pain program and was denied as was the appeal.

REQUESTED SERVICE(S)

20 sessions of chronic pain management program.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Mr. ____ has failed conservative treatment for his symptoms from the injury that occurred on _____. However, to be a candidate for a multidisciplinary chronic pain program, one criteria is to be psychiatrically stable and able to endure the rigors of these intense programs. Certainly, the submitted records do not support the fact that Mr. ____ be stable psychiatrically to successfully work through an intense pain management program. He would need to be significantly improved from a psychiatric perspective to be reconsidered for the requested services. This viewpoint is supported by generally accepted guidelines such as ACOEM, peer review literature and standard text book on chronic pain. Therefore, the requested services are denied.

RE: ____

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 12th day of December, 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell