

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

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Austin, Texas 78735

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

| | |
|--|--------------------------------|
| TDI-WC Case Number: | |
| MDR Tracking Number: | M2-07-0369-01 |
| Name of Patient: | |
| Name of URA/Payer: | TPCIGA |
| Name of Provider: (ER, Hospital, or Other Facility) | Valley Total Healthcare System |
| Name of Physician: (Treating or Requesting) | Ruben Pechero, MD |

December 1, 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 1, 2006
Notice of Independent Review Determination
Page 2

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Valley Total Healthcare System
Ruben Pechero, MD
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

1. TWCC Forms
2. Clinical notes from Dr. Ruben Pechero
3. Adverse determination and denial letters per Dr. Brylowski
4. Psychological evaluation on 02-09-06 by Alma Castaneda, LPC with subsequent clinical notes on counseling sessions.
5. Report of Medical Evaluation dated 03-09-95
6. Letter on 11-9-06 from Texas Property and Casualty Insurance Guaranty Association

CLINICAL HISTORY

Mr. ____ sustained a work related injury on _____. He eventually had a multilevel laminectomy and fusion on 12-05-94. Postoperatively, he received extensive conservative treatment including physical therapy, medication, activity restrictions, home exercise program, and counseling. He continued to have low back pain.

REQUESTED SERVICE(S)

Four sessions of individual counseling

DECISION

Denied

RATIONALE/BASIS FOR DECISION

Mr. ____ had an injury on ____ with extensive treatment including surgery. He continues to have pain through 2006. It appears he has a chronic pain issue along with major depression. Standards of care reflect that four sessions of counseling will not significantly affect his current pain, depression, quality of life, or ability to return to work. He has had extensive treatment for his injury including counseling and he continues to have pain and require the same level of medication and treatment. Unfortunately his improvement has ceased long ago. This is supported by the submitted records and standard of care for chronic pain patients. Accepted guidelines such as ACOEM and the Philadelphia Panel support this as well.

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 5th day of December, 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell