

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-07-0571-01
Name of Patient:	
Name of URA/Payer:	Zurich American Insurance
Name of Provider: (ER, Hospital, or Other Facility)	Alta Vista Healthcare
Name of Physician: (Treating or Requesting)	Donald Dutra, MD

January 22, 2007

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.

January 22, 2007
Notice of Independent Review Determination
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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Alta Vista Healthcare
Donald Dutra, MD
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

Submitted documents for review include:

- Denial letters from Dr. Evers dated 10/18/06 and Dr. Griffith on 11/22/06.
- Letter from Phil Bohart dated 10/12/06.
- Letter from Ronald Johnson dated 1/15/07.
- MMI evaluation by Dr. Alexander on 9/7/06.
- Records from Alta Vista.
- Letter to reconsider denial dated 11/13/06.
- Clinical notes from Dr. Dutra.
- PPE by Pratt, PT, on 9/18/06.
- Records from Dr. Kruczck.

CLINICAL HISTORY

Ms. ____ sustained a work related injury on _____. She had extensive evaluation and treatments including medications, physical therapy, being off work, multiple epidural steroid injections, and multiple versions of a work hardening program. A letter from Phil Bohart dated 10/12/06 states the patient showed some improvement from 2/3/06 through 9/15/06 that he attributes to an interdisciplinary pain rehabilitation program. Dr. Alexander's assessment on 9/7/06 is that this patient has reached MMI with a 10% impairment rating.

REQUESTED SERVICE(S)

Chronic Pain Management Program x 10 days/session.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This patient has a chronic pain syndrome and was an appropriate candidate for a chronic pain program. In fact, she had 20 sessions (records not enclosed) and per Phil Bohart's letter showed some improvement from 2/3/06 to 9/15/06. However, it is unclear from the records provided if the patient has had a steady improvement or has plateaued or regressed by the end of those 20 visits. Additionally, MMI done by Dr. Alexander on 9/7/06 indicated the patient had reached MMI on that date from her original injuries sustained in _____.

RE: ____

He gave her an impairment rating of 10%. Therefore, since she had apparently reached MMI and there is insufficient objective, clinical documentation to show sustained and continued improvement with this program, continued approval for these services cannot be justified nor can medical necessity be proven from the submitted documents. So, the non-authorization of these services is upheld. This viewpoint is supported by ACOEM and Inter Qual Guidelines, standard textbooks, and accepted peer review literature.

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 23rd day of January, 2007.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell