

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-07-0756-01
Name of Patient:	
Name of URA/Payer:	Liberty Mutual Fire Insurance
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Sybil Reddick, MD

February 8, 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.

February 8, 2007
Notice of Independent Review Determination
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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Advantage Healthcare Systems
Sybil Reddick, MD
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

- Denial letters from Liberty Mutual
- TDI paperwork
- Evaluation from Vickie Johns dated 6/9/06
- PPE by Dr. Galloway, DC on 9/26/06
- Letters from Advantage Healthcare Systems
- Denial letters per Jerome Schmidt, Ph.D. from Medical Review Institute of America
- Clinical notes from Dr. Reddick for dates 4/17/06 to 10/26/06

CLINICAL HISTORY

Ms. ____ suffered a knee injury on _____. She had extensive treatment including medications, rest, ice, heat, physical therapy, electrical stimulator, acupuncture, and chiropractic care. Eventually she had arthroscopic surgery in 1996 and there is mention of a second arthroscopic surgery in 1997. At time of request patient has chronic pain syndrome, depression, anxiety, and a history of bipolar disorder. Requested services were denied as was the appeal.

REQUESTED SERVICE(S)

Chronic Pain Management Program

DECISION

Uphold denial.

RATIONALE/BASIS FOR DECISION

Unfortunately this patient continues to have symptoms over 12 years after her original injury. The request for chronic pain management program is not authorized for a variety of reasons. First, the patient has significant psychiatric issues that appear not to have been addressed. Depression, anxiety, history of bipolar, malingering, and pain magnification need to be addressed and treated appropriately before any patient can enter the intensive nature of a multidisciplinary chronic pain program. Next, the patient has been on medications for years. Dr. Reddick did note to decrease and eventually stop all medication but the latest progress note on 10/26/06 shows the same amount of medications were still being refilled. No documentation is submitted to see if non-narcotic medications have been tried. No

RE: ____

urine drug tests were noted to verify compliance. No documents submitted show if the patient's deconditioning have been addressed. Lastly, an intensive program should be reserved for patients who would most likely benefit this treatment when they meet the appropriate criteria. Unfortunately, there is little likelihood this patient, given her circumstances and length of time from original injury, would derive any significant benefit from the requested program. Therefore, the requested services are not authorized for the reasons listed. This viewpoint is supported by standard textbooks, peer-reviewed literature and accepted guidelines such as CMS, ACOEM, and the Official Disability Guidelines.

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 9th day of February, 2007.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell