

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

| | |
|---|---------------------------|
| TDI-WC Case Number: | |
| MDR Tracking Number: | M2-07-0757-01 |
| Name of Patient: | |
| Name of URA/Payer: | |
| Name of Provider: <small>(ER, Hospital, or Other Facility)</small> | Canton Healthcare Systems |
| Name of Physician: <small>(Treating or Requesting)</small> | Bryan Weddle, DC |

March 12, 2007

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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.

March 12, 2007
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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Canton Healthcare Systems
Bryan Weddle, DC
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

Available documentation received and included for review consisted of records from Drs. Weddle (DC), Willis (MD), Vaughan (MD), Branch (MD) Bander (DO) Ellman (MD), Podleski (MD) Chronic Pain Management intake assessments, IME's by Drs. Kern (MD), Pinson (MD), Kantipong (MD) Taylor (MD) and Battle (MD), multiple MRI and EMG/NCV reports, FCE's and peer preauth denials.

CLINICAL HISTORY

Mr. ____, a 61-year-old male, sustained an on-the-job injury as a result of a slip and fall injury while working for the _____. He struck his head and there was temporary loss of consciousness, he suffered a concussion, broke three ribs, separated his left shoulder, injured his left hip, neck and back. Subsequently he suffered with neck and upper extremity pain, (left more so than right), left-sided shoulder pain, low back and left leg pain. He underwent a surgical repair for a torn rotator cuff in May of 2003, and an anterior cervical discectomy and fusion at C5/C6 in November of 2003. He continued with chronic pain despite multiple treatment interventions including chiropractic/physical therapy, surgery, ESI's pain management. He was followed by Dr. Willis pain management purposes was medicated with Ultracet, Mobic Zoloft and Trazodone. He had individual psychotherapy for chronic pain syndrome / depression.

He suffered a fall in early ____ and sustained a compression fracture of T12. This exacerbated his low back and leg pain. He was placed at MMI (statutory) on 11/6/04 with a 25% whole person impairment rating.

EMG/NCV as of 12/20/04 showed an L5 radiculopathy on the right.

This is a gentleman who has had numerous previous work-related injuries, in _____ (lumbar spine), _____ (cervical and lumbar spine), and _____ (left shoulder and lumbar spine).

Dr. Weddle withdrew as the treating doctor for the patient on 08/25/06.

RE: _____

Recommendation for chronic pain management has been made as the patient apparently continues with significant difficulties.

REQUESTED SERVICE(S)

Prospective medical necessity of pain management program, for 10 days.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

A chronic pain program involves a multidisciplinary approach and is reserved typically for outliers of the normal patient population, i.e. poor responders to conventional treatment intervention, with significant psychosocial issues and extensive absence from work^(1,2).

Chronic pain or chronic pain behavior is defined as devastating and recalcitrant pain with major psychosocial consequences. It is self sustaining, self regenerating and self-reinforcing and is destructive in its own right as opposed to simply being a symptom of an underlying somatic injury. Chronic pain patients display marked pain perception and maladaptive pain behavior with deterioration of coping mechanisms and resultant functional capacity limitations. The patients frequently demonstrate medical, social and economic consequences such as despair, social alienation, job loss, isolation and suicidal thoughts. Treatment history is generally characterized by excessive use of medications, prolonged use of passive therapy modalities and unwise surgical interventions. There is usually inappropriate rationalization, attention seeking and financial gain appreciation⁽²⁾.

This gentleman satisfies the above requirements for a chronic pain management program. He has had significant and various attempts at intervention, yet continues with difficulty. Due to his age and multiple areas of injury, a multidisciplinary chronic pain management course would seem quite appropriate and medically necessary.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and

RE: ____

complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

1/ CARF Manual for Accrediting Work Hardening Programs

2/ AMA Guides to the Evaluation of Physical Impairment, 4th Edition

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 March, 2007.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell