

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Austin, Texas 78735

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0805-01
Name of Patient:	_____
Name of URA/Payer:	Zurich American Insurance
Name of Provider: (ER, Hospital, or Other Facility)	Active Behavioral Health & Pain Rehab.
Name of Physician: (Treating or Requesting)	Marivel Subia, DC

April 3, 2006

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.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Active Behavioral Health & Pain Rehab.
Marivel Subia, DC
Division of Workers' Compensation

CLINICAL HISTORY

Materials Submitted for Review:

TDI/WCD Independent Review Request / Notification of IRO
Assignment

MDR Request / Response

Service Request Review / Concentra

Carrier's Position / Flahive, Ogden & Laston

Designated Doctor Reports / Jean F. Coria, MD

Pain Management Order & Reports / Steven Eaton, MD

Neurology Peer Review / Wayne Gordon, MD

Chiropractic Notes and Reports / Summit Rehabilitation Center /
Marivel Subia, DC

Chiropractic Peer Review Reports / Shawn Fyke, DC

Medical Notes and Reports / Karla R. Dick, DO

FCE Reports / Robert Peterson, DC

IME Reports / Daniel Foster, DO

Medical Reports and Notes / Andrew Small, MD

Chiropractic Notes and Reports / James Orr, DC

Pain Management Request / Phil Bohart, MS, LPC

Reports / Active Behavioral Health & Pain Rehab

Electrodiagnostic Reports / Jonathan Walker, MD

Lumbar MRI Reports / Raman Mocharla, MD

Available information suggests that this patient reports an injury to upper back while lifting a picture on the production line at work on _____. He presented initially to a company doctor on 11/02/04 but these records are not provided for review. He was apparently told he had two desiccated discs in his lower back. He later presented to a chiropractor, Dr. Subia on 11/08/04 and received x-rays and conservative treatment. An MRI is performed on 12/03/04 suggesting bilateral neuroforaminal narrowing at L4/5 and L5/S1, mild broad based disc bulging and additional degenerative changes of the lumbar

facet joints. The patient appears to have undergone extensive chiropractic therapy, injections, rehabilitation and psychotherapy over a period of several months. An EMG and nerve conduction study is performed 07/06/05 and found essentially normal. The patient appears to undergo several medical and osteopathic and pain management evaluations that appear to have led to medial branch blocks and radiofrequency ablation therapy in addition to multiple oral pain, anxiety and depression medications. Designated doctor evaluation is performed 01/24/06 by a Dr. Coria. The patient is found to have unresponsive conditions of sciatica, myositis and intervertebral disc disease with myelopathy. Dr. Coria recommends that this patient have a formal neurosurgical evaluation prior to any additional active, passive or behavioral medicine interventions.

REQUESTED SERVICE(S)

Determine medical necessity for proposed chronic pain management program x10 sessions.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Available documentation **does not support medical necessity** for progressing this patient in to a chronic behavioral pain management program of this nature at this time. A formal neurosurgical evaluation appears indicated before medical necessity for requested pain management program could be appropriately determined.

1. National Guideline Clearinghouse *Clinical practice for chronic non-malignant pain syndrome patients II*, J Back Musculoskeletal Rehabilitation 1999, Jan 113:47-58.
2. Aronoff GM, McAlary PW, Witkower A, et al. Pain treatment programs: Do they return workers to the workplace? Occup Med. 1988;3(1):123-136.
3. Vines SW, Cox A, Nicoll L, et al. Effects of a multimodal pain rehabilitation program: A pilot study. Rehabil Nurs. 1996;21(1):25-30, 40.
4. Reinking J, Tempkin A, Tempkin T. Rehabilitation management of chronic pain syndromes. Nurse Pract Forum. 1995;6(3):139-144.
5. Burns JW, Sherman ML, Devine J, et al. Association between workers' compensation and outcome following multidisciplinary

treatment for chronic pain: Roles of mediators and moderators. Clin J Pain. 1995;11(2):94-102.

6. Jensen MP, Turner JA, Romano JM. Correlates of improvement in multidisciplinary treatment of chronic pain. J Consult Clin Psychol. 1994;62(1):172-179.

7. Flor H, Fydrich T, Turk DC. Efficacy of multidisciplinary pain treatment centers: A meta-analytic review. Pain. 1992;49(2):221-230.

8. Csordas TJ, Clark JA. Ends of the line: Diversity among chronic pain centers. Soc Sci Med. 1992;34(4):383-393.

9. Deardorff WW, Rubin HS, Scott DW. Comprehensive multidisciplinary treatment of chronic pain: A follow-up study of treated and non-treated groups. Pain. 1991;45(1):35-43.

10. Rowlingson JC, Hamill RJ. Organization of a multidisciplinary pain center. Mount Sinai J Med. 1991;58(3):267-272.

11. Peters JL, Large RG. A randomized control trial evaluating in- and outpatient pain management programmes. Pain. 1990;41(3):283-293.

12. International Association for the Study of Pain. Task Force on Guidelines for Desirable Characteristics for Pain Treatment Facilities, 1990.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

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 April 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell