

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-1858-01
Name of Patient:	
Name of URA/Payer:	Texas Mutual Insurance
Name of Provider: (ER, Hospital, or Other Facility)	Bexar County Health Care
Name of Physician: (Treating or Requesting)	Rolando Rodriguez, MD

September 20, 2006

An independent review of the above-referenced case has been completed by a physician (board certified) in neurology. 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.

September 20, 2006
Notice of Independent Review Determination
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Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: _____
Bexar County Health Care Systems
Rolando Rodriguez, MD
Division of Workers' Compensation

RE: ____

DOCUMENTS REVIEWED

1. Notification of IRO Assignment
2. Initial comprehensive evaluation note from Orthopedic Pain Management, PA, 11-04-04
3. Dr. S. Ali Mohamed, MD.
4. Follow-up visits from Dr. Mohamed
5. Elite MRI of San Antonio, MRI of the left hand report of 11-16-04
6. Evaluations from Dr. Rolando F. Rodriguez
7. Report of medical evaluation, TWCC Form-69, designating 4% total body impairment on 04-03-06.
8. MMI rating of ____ by Dr. Katharina Hathaway, MD of 04-03-06
9. Diagnostic interview and treatment plan by Bexar County Health Care Systems 05-19-06
10. Utilization review evaluation by Grace Bryant, LPN, 06-01-06.
11. Utilization review decision 06-19-06 by Esther Garza, LVN

CLINICAL HISTORY

A 59-year-old female reporting severe pain in the palmar region of the left hand proximal to the index finger coming on after repetitive movements "slamming" the left hand onto receipts to flatten them, preparing them for scanning. Pain has gradually increased. She has undergone multiple evaluations. She has received various recommendations for surgical procedures. She has had multiple medications and physical therapy.

REQUESTED SERVICE(S)

Pre-authorization for 10 sessions of chronic pain management

DECISION

Approve

RATIONALE/BASIS FOR DECISION

This decision is based on a comprehensive process including extensive literature review and over 25 years of clinical experience. ____'s initial visual analog scale pain rating of 3-4/10 increased to 8-9/10 from her visit with Dr. Mohamed on 11-04-04 to her diagnostic interview and treatment plan from Bexar County Health

RE: ____

Care Systems on 5-19-06. This is the only example of her total lack of understanding of even mild chronic pain. It is only a chronic pain management treatment plan which can have any possibility of changing a patient's perception of what this type of pain syndrome represents and treat and educate a person into a new conceptualization of what has happened to them and to accept this new situation and to successfully return them to a work environment. This patient has obviously had multiple, varied recommendations for care from conservative to surgery. Certainly this was a very mild injury from its description. Behaviorally-based pain management is by far the best chance to get Ms. ____ successfully back into the work force by physical and emotional modalities.

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 21st day of September, 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell