

May 14, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0888-01

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing psychologist on the \_\_\_ external review panel. The \_\_\_ psychologist reviewer signed a statement certifying that no known conflicts of interest exist between this psychologist and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ psychologist reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 50 year-old female who sustained a work related injury on \_\_\_. The patient worked as a teaching assistant and while at work she slipped and fell in the kitchen injuring her left knee and low back. Since the injury the patient has complained of low back and bilateral leg pain. The patient underwent lumbar spine X-Rays and an MRI showed grade 1 spondylosthesis at L4-5 with moderate circumferential stenosis. The patient has been treated conservatively with physical therapy and with epidural steroid injections. The patient has also undergone lumbar decompression, discectomy, fusion and spinal instrumentation at L4-5. The patient has undergone two psychological evaluations, (1/22/03, 4/14/03) which indicate the presence of affective disturbance (depression, anxiety) secondary to chronic pain syndrome.

### Requested Services

Individual psychological counseling times 10 sessions.

### Decision

The Carrier's denial of authorization for the requested services is overturned.

### Rationale/Basis for Decision

The \_\_\_ psychologist reviewer noted that the patient sustained a work-related injury on \_\_\_. The \_\_\_ psychologist reviewer indicated that the patient has been diagnosed with chronic pain syndrome with associated clinical levels of depression and anxiety. The \_\_\_ psychologist reviewer explained that the psychological evaluations concluded that individual psychotherapy would likely be beneficial for the patient. The \_\_\_ psychologist reviewer indicated that there is ample empirical evidence to suggest that the incidence of affective distress is high in patients with chronic pain syndrome and that untreated depression in particular is a strong predictor of long-term disability.

The \_\_\_ psychologist reviewer explained that there are excellent data showing that psychological treatment yields positive health benefits for patients with chronic pain. The \_\_\_ psychologist reviewer also explained that individualized psychological interventions that focus on stress management training, relaxation training, cognitive-behavioral therapy, and contingency management techniques have strong empirical support and validity. The \_\_\_ psychologist reviewer further explained that major treatment guidelines have been established that include the provision of psychological treatments and that these include guidelines developed or adapted by the American Academy of Physical Medicine and Rehabilitation, the American Pain Society, the American Academy of Pain Management, and the Joint Commission on Accreditation of Healthcare Organizations. Therefore, the \_\_\_ psychologist consultant has concluded that the requested psychological counseling times 10 sessions is medically necessary to treat this patient's condition at this time. (SH Sanders et al; J. Back Musculoskeletal Rehab: 1995, SH Sanders et al, J. Back Musculoskeletal Rehab: 1999, DH Phillips; JAMA: 2000, WR Nielson; Clinical J. Pain: 2001, BE Compus; J. Consult Clin Psychol: 1998, M. Ericsson; Disabil Rehabil: 2002.)

This decision is deemed to be a TWCC Decision and Order.

#### YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 (ten) days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

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 14<sup>th</sup> day of May 2003.