

September 9, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1437-01

___ 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 physician on the ___ external review panel. This ___ reviewer has been certified for at least level I of the TWCC ADL requirements. This physician is board certified in psychiatry. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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 ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old female who sustained a work related injury on ___. The patient reported that while at work she slipped and fell injuring her hip. The patient was diagnosed with cervical, thoracic and lumbar neuritis, S.I. joint dysfunction, sacrolitis, multiple cervical/thoracic and lumbosacral trigger points and radiculopathy in the left arm and left leg. The patient underwent an MRI on 2/20/01 that showed a 2mm posterior central disc protrusion at the L5-S1, 2mm disc protrusions at the C4-5, C5-6 and C6-7 levels. An EMG on 3/8/01 showed severe left carpal tunnel syndrome. The patient has been treated with cervical epidural injections, physical therapy, trigger point injections and chiropractic manipulations. The patient was also treated with a pain management, left carpal tunnel release and medications.

Requested Services

Individual psychotherapy one time a week for 6 weeks for a total of six sessions (90844).

Decision

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

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 44 year-old female who sustained a work related injury on ___. The ___ physician reviewer also noted that this patient has neuritis and sacrolitis with MRI findings of cervical protrusions and arm and leg radiculopathy on the left. The ___ physician reviewer further noted that this patient has subsequent overt persistent chronic pain syndrome secondary to failed chiropractic treatments, trigger point injections, epidural cervical, thoracic and lumbar injections, pain medications and traditional somatic

approaches. The ___ physician reviewer indicated that this patient has underlying emotional reasons for the ongoing maintenance for her pain and regressive disability and subsequent secondary depression. The ___ physician reviewer explained that this patient requires a psychological evaluation to determine the psychogenic influence upon her chronic pain condition. The ___ physician reviewer also explained that the patient's chronic pain, including symptoms related to chronic carpal tunnel difficulty, can be initially assessed and perhaps well addressed with the recommendation of 6 once a week one on one therapy sessions. Therefore, the ___ physician consultant concluded that the requested individual psychotherapy one time a week for 6 weeks for a total of six sessions (90844) is medically necessary to treat this patient's condition at this time.

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/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

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 10th day of September 2003.