

September 17, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-03-1707-01**

\_\_\_ 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. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in psychology. 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 31 year-old male who sustained a work related injury on \_\_\_. The patient reported that while at work he was attempting to retrieve a bucket of water from atop a ladder when he fell backwards to the ground. The patient reported that he injured his pelvis and upper back. The patient was evaluated at an emergency room where he underwent X-Rays and was treated with pain medication. Diagnoses for this patient have included severe sprain/strain of the low back and knee area and a disc bulge at the L4-L5 level. The patient has been treated with epidural steroid injections, therapy and rehabilitation.

### Requested Services

Biofeedback times 10 sessions, 45-60 minutes, once a week.

### Decision

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

### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 31 year-old male who sustained a work related injury to his back and pelvic on \_\_\_. The \_\_\_ physician reviewer also noted that the patient has been treated with epidural steroid injections, manipulations, rehabilitation and muscle retraining. The \_\_\_ physician reviewer indicated that the patient is reported to be anxious even though he is gradually improving. The \_\_\_ physician reviewer explained that the patient reports mostly low dull pain, works 8 hours a day with mild restrictions and is currently on no active medications for pain or his mental status. The \_\_\_ physician reviewer also

explained that the documentation provided does not indicate why the requested treatment would be efficacious in this particular patient's condition. The \_\_\_ physician reviewer also explained that a selective serotonin reuptake inhibitor with brief confronting psychotherapeutic treatment has not been tried and documented as a failed treatment. Therefore, the \_\_\_ physician consultant concluded that the biofeedback times 10 sessions, 45-60 minutes, once a week is not 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 17th day of September 2003.