

NOTICE OF INDEPENDENT REVIEW DECISION

Date: September 17, 2003

RE: MDR Tracking # M2-03-1711-01
IRO Certificate # 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Psychologist reviewer. The Psychologist reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant is a 40 year old Hispanic male who was injured on ___ while working for the ___. He reportedly was lifting the jaws of life from a shelf in a truck when he felt a sudden pain in his lower back. He was referred to ___ for treatment of these injuries. He reportedly was placed in a work hardening program, but had difficulty with the program. He elected to change treating doctors to ___ of the ___. ___ initially evaluated him on 5/27/03 and has continued treating him. He has had numerous work related injuries. He reported injuries that included a left shoulder injury in ___ and a back injury in ___ which resulted in his being unable to work for 9 months. He returned to work in May 2002 and was injury on ___ when the current injury occurred. He attributes his injuries to being "accident prone". ___ referred him for epidural steroid injections, manipulations, and counseling. He was evaluated by ___ at the ___ who diagnosed him with a pain disorder with both psychological factors and Axis III disorder. She described him as depressed with a tearful affect. In the initial evaluation the claimant filled out a questionnaire indicating that he was tearful, his sleep was disturbed secondary to pain, that his weight had increased greater than 10 pounds since the injury, that he has experienced a loss of interest and enjoyment of previously enjoyable activities and has become irritable and angry.

Requested Service(s)

Individual counseling for 6 sessions for 45-60 minutes each once per week.

Decision

I disagree with the insurance carrier that the services are not medically reasonable or necessary.

Rationale/Basis for Decision

The evaluation performed by ___ and ___ supports that the claimant is suffering symptoms consistent with depression that would typically result from an injury with persistent pain. There is no indication that

a pre-existing psychological or psychiatric condition was present. Therefore, the symptoms are attributable to the compensable injury. The request falls within the standard of care for individual counseling, both in terms of frequency and duration.

YOUR RIGHT TO REQUEST A HEARING

Either party to 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) calendar days of your receipt of this decision (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.