

April 9, 2004

Ms. Pamela Jones  
BHCA, PC  
2450 Fondren, Suite 312  
Houston, Texas 77063

Ms. Paula Mulvihill  
Lumbermens Mutual Casualty  
P.O. Box 670688  
Houston, Texas 77267-0688

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-04-0581-01**  
**TWCC #: \_\_\_\_\_**  
**Injured Employee: \_\_\_\_\_**  
**Requestor: BHCA, PC**  
**Respondent: Lumbermans Mutual Casualty Company**  
**MAXIMUS Case #: TW04-0027**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS 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 MAXIMUS for independent review in accordance with this Rule.

MAXIMUS 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 MAXIMUS 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 psychiatry. The MAXIMUS 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 MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a 36 year-old male who sustained a work related injury on \_\_\_\_\_. The patient reported that while at work he fell into a metal table while carrying welding equipment. Initial treatment consisted of pain medications, bed rest, physical therapy, hot/cold packs and electrical stimulation. The patient transferred his care to the current treating physician and was continued on conservative care that included passive modalities, active rehabilitation, and work hardening. The patient has undergone MRIs, EMG studies, and a discogram and myelogram. On 12/12/01 the patient underwent a lumbar fusion followed by a course of post surgical

rehabilitation. Postoperatively, the patient has continued complaints of low back pain, left leg pain, and bilateral leg weakness as well as other personal complaints. The patient has been referred for further psychological evaluations.

### Requested Services

Psychological evaluation.

### Decision

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

### Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a 36 year-old male who sustained a work related injury on \_\_\_\_\_. The MAXIMUS physician reviewer indicated that despite a thorough course of treatment, the patient has become increasingly disabled, severely depressed, and increasingly unable to perform activities of daily living and is experiencing a feeling of incompetence in supporting his family. The MAXIMUS physician reviewer noted that the patient has been treated with an L5-S1 lumbar fusion, an intensive pain management program, electrical stimulation, varied analgesic and anti-inflammatory agents, physical therapy, and other modalities as described in the documentation provided. The MAXIMUS physician reviewer indicated that the patient has now become chronically depressed and continues to suffer from intensive low back/leg and now testicular pain, tingles, sexual dysfunction, and poor sleep despite being treated with Zoloft, Neurontin, and Darvocet.

The MAXIMUS physician reviewer noted that psychological testing performed in 9/02 confirmed chronic depression as a compensable and ongoing state related to his original injury. The MAXIMUS physician reviewer explained that it also revealed excessive and unrealistic patient expectations for total relief if he is to be able to return to a normal life. The MAXIMUS physician reviewer indicated that this patient requires a full individual, personal psychological and psychiatric assessment of his current emotional status. The MAXIMUS physician reviewer explained that this patient is doing poorly and is settling into a chronic, regressive, vulnerable reaction to his pain, his injury and his complex and unsuccessful past surgical and non-surgical treatments. The MAXIMUS physician reviewer also explained that a psychiatric evaluation is medically necessary to evaluate his current state of behavior, his underlying Axis II pathology, increase his antidepressant medication, and to reinforce new applications of behavioral modalities to reduce pain and regression. Therefore, the MAXIMUS physician consultant concluded that the requested psychological evaluation 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,  
**MAXIMUS**

Elizabeth McDonald  
State Appeals Department

cc: Texas Workers Compensation Commission

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 9<sup>th</sup> day of April 2004.

Signature of IRO Employee

Name Elizabeth McDonald