

June 14, 2004

MDR Tracking #: M2-04-1329-01

IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this 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, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Psychiatry. The reviewer is on the TWCC Approved Doctor List (ADL). The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors 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 the dispute.

#### CLINICAL HISTORY

According to the records reviewed, \_\_\_ was ascending some stairs at his place of employment on \_\_\_ when he slipped and hit his left knee. Subsequently he has had chiropractic care, medications for pain, physical therapy, work hardening and counseling. An evaluation accomplished in October 2003 indicates he is having an Adjustment Disorder with Mixed Emotional Features. At the time he reported sadness, irritability, sleep disturbance and reduced ability to participate in activities. The staffing notes from October to November 2003 indicate that this gentleman has depression and anxiety and that he is either not working on the depression or is not making satisfactory gains on this issue. There are a number of notations that this patient is a candidate for chronic pain management. There is a notation by \_\_\_ in December 2003 indicating that a Chronic Pain Management Program was requested and that he disagrees with the designated doctor exam's conclusion that this patient is at MMI. The request dated 03/16/04 for six individual sessions indicated that the individual counseling was helping him control his depression and anxiety; however, they also stated the depression and anxiety are severe and additional sessions are requested. They note he did not benefit from work hardening. They state their treatment goals are to have the patient taking care of his "everyday needs" and get him to MMI and not dependent upon medications or the medical system. The initial denial was because the reviewer was "unable to determine techniques, plan, progress, can't tell if reasonable and necessary." The reviewer apparently tried to call the office but received no call back. The appeal letter dated 04/02/04 stated the patient had benefited from work hardening and the individual therapy in the past.

He responded when he acknowledged his depression. The appeal asserts that the individual psychotherapy will help cure and relieve his condition and promote recovery from his ailments and return him to work. The second denial is based on similar rationale as the first: “there are no indications with this request of the techniques, treatment plan, progress in treatment or current status. In particular, there is no indication of why the patient has failed to benefit in a substantial and sustained manner to the prior extensive treatment. There is no explanation of why the patient’s level of depression has increased since the evaluation of last year. The medical necessity of additional psychotherapy has not been established.”

#### REQUESTED SERVICE

Six additional sessions of psychotherapy are requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

The providers have not provided sufficient information to substantiate the medical necessity of further individual psychotherapy sessions. The requests are vague and have mixed information. One request states that he did not respond to work hardening; the other states that he did well in work hardening. The requests note response to individual treatment, but they state his mood and anxiety symptoms are worse, and the medical notes and staffing notes do not reflect any substantive gains through the therapy. The treatment goals “taking care of their everyday needs,” getting him to MMI, and reduce medical dependence and medications are vague and in some ways do not seem to match with the clinical picture. For example, there is no indication in the notes of abuse of medications, and it is unlikely that given the diagnosis of degenerative joint disease that he will not require further medication treatment. Further, the therapeutic technique is not specified. Are they employing psychoanalysis, supportive therapy, cognitive behavioral therapy, or interpersonal therapy? Since it does not appear that the prior therapy had any lasting effect, it is reasonable for the carrier to want to know the specific technique to be employed to assure that it is a scientifically supported method for the problem. Finally, the treatment notes clearly indicate that the providers feel that this patient is a candidate for Chronic Pain Management, a tertiary level of care. This indicates that they feel primary and secondary interventions such as individual therapy have failed and are not going to be successful without inclusion in a multidisciplinary program.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee’s policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

### **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.

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 14<sup>th</sup> day of June 2004.**