

August 11, 2004

MDR #: M2-04-1559-01

IRO Cert# 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management and Neurology and is currently listed on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: letter of medical necessity, office notes, daily progress notes and FCE.

Information provided by Respondent: correspondence and designated doctor exams.

Information provided by Treating Doctor: office notes.

Information provided by ___: office notes.

Clinical History:

This claimant sustained a work-related injury on ___ that resulted in injury to his left shoulder. There appears to be a history of previous left shoulder injury in the year ___. The claimant has undergone physical therapy, as well as a chronic pain management program, with cooperation felt to be "poor". The claimant has been treated with pain medications in addition to shoulder surgery and physical therapy, and he is also on some antidepressants. His pain medications have included short-acting narcotics in addition to his anti-inflammatories such as Vioxx, muscle relaxants such as Zanaflex, and other analgesics such as tramadol/Ultracet.

Disputed Services:

Individual psychotherapy twice weekly for four weeks (eight sessions total-component of pain management program)

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that individual psychotherapy in dispute as stated above is not medically necessary in this case.

Rationale:

Review of medical records indicate this claimant has already undergone several treatment modalities, including participating in a chronic pain management program, where his participation was felt to be "poor". At this point, the requested services are solely for counseling and psychotherapy, for a total of 8 sessions. This would not be expected to result in any significant overall or long-term improvement in the patient's chronic pain condition that has now been present for several years. His depression diagnosis, if it is felt to be an outcome of his work-related injury, may need further treatment by a psychiatrist in case a change needs to be made to the present medication. Though the participation in a multidisciplinary chronic pain program that may address not only his emotional psychological problems but also his physical pain condition may be appropriate, though it does not appear this claimant would be cooperative.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this 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 ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©)

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 twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you **five (5) 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, Texas Workers' Compensation Commission, MS-48, 7551 Metro Center Dr., Ste. 100, Austin, TX 78744-1609

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.

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 August 11, 2004.