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NOTICE OF INDEPENDENT REVIEW DECISION

Date: January 25, 2005

Requester/ Respondent Address:

TWCC
Attention: Gail Anderson
7551 Metro Center Drive, Suite 100, MS-48
Austin TX 78744-1609

Dr. E, MD
Attn: _____
Fax: 956-686-9444
Phone: 956-686-9223

Service Lloyds Insurance Co c/o Harris & Harris
Attn: _____
Fax: 512-346-2539
Phone: 512-346-5533

RE: Injured Worker:

MDR Tracking #: M2-05-0582-01
IRO Certificate #: 5242

Forté 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 Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté 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 psychiatric reviewer (who is board certified in psychiatry) who has an ADL certification. The physician 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.

Submitted by Requester:

- Notice of IRO assignment
- Letter of medical dispute

- Letters of non-authorization from Corvel
- Authorization for individual management sessions from Corvel
- Mental Health evaluation, Advanced Wellness Institute dated 7/22/04
- 6 progress summaries from Advanced Wellness Institute dated 11/17/04
- Appeal for services from Advanced Wellness Institute dated 11/24/04
- Progress notes from individual psychotherapy spanning the period from 8/04 through 11/04
- Note from Dr. P dated 11/6/03
- Retrospective Chiropractic review dated 1/25/04
- Examination dated 1/28/04 by Dr. B
- Report of medical evaluation
- Second opinion from Dr. G dated 7/16/03

Submitted by Respondent:

- Letter from ____, dated 1/17/05
- Notice of IRO assignment
- Letters of non-authorization from Corvel
- Medical review of records from Dr. L
- Disability evaluation from Dr. E, dated 1/26/04
- Evaluation by Dr. B dated 2/4/04
- Retrospective Chiropractic review by Dr. K

Clinical History

____ was reportedly injured when he slipped and fell on _____. According to the records submitted, he was treated and then returned to work on modified duty, but then re-injured himself while lifting a heavy tire. He has been treated conservatively with physical therapy, chiropractic manipulations, TENS units, and medication management. He has had an MRI to evaluate his cervical spine. He was also authorized to participate in individual psychotherapy. The mental health evaluation from the Advanced Wellness Institute indicates their diagnoses for him include a pain disorder, major depressive disorder, sleep disorder and a relational problem. He apparently did not make substantial gains with individual therapy, and the Advanced Wellness Institute subsequently requested a full chronic pain management program which is not authorized due to lack of medical necessity being shown. The most recent examination that is submitted by both the carrier and the provider is from Dr. B. He notes that he reviewed a surveillance video of the claimant going up and down ladders, working on his roof manipulating a satellite dish without apparent evidence of functional limitation. He indicates a normal physical examination with no evidence of physical limitations. He feels the claimant should be able to return to work. It is also noted in the individual therapy progress notes that the claimant states on numerous occasions that he wants to return to work but he feels he is being prevented from doing so by not being released to work and is angry with the insurance carrier, lawyer and doctors.

Requested Service(s)

Thirty (30) sessions of a chronic pain management program.

Decision

I agree with the insurance carrier that medical necessity is not demonstrated for this claimant to participate in a chronic pain management program.

Rationale/Basis for Decision

According to the individual therapy notes, the claimant wants to return to work but feels the doctors, attorney, and insurance carrier are preventing him. Given these noted desires and that there is no functional limitation in the most recent physical examination provided, a fact that is supported by surveillance video, medical necessity is not demonstrated for this claimant to participate in a chronic pain management program.

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) 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.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 25th day of January 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: