March 14, 2005

BHCA
Attn: L. Kenney
P.O. Box 25006
Ft. Worth, TX 76124

VIA FACSIMILE
Alternative Services Concepts
Attn: Bob Collier

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-0872-01
TWCC #:
Injured Employee:
Requestor: BHCA
Respondent: Alternative Services Concepts
MAXIMUS Case #: TW05-0029

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 and is familiar with the condition and treatment options at issue in this appeal. 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 male who sustained a work related injury on ___. The patient reported that while at work he was sliding a box of steel caps off from a pallet when the box began to fall. The patient reported that he attempted to stop the box from falling and injured his left arm. The treatment for this patient's condition has included medications, passive modalities including heat/ice, traction, myofascial release, chiropractic manipulation, a TENS unit, physical and

occupational therapy, and injections. The patient has continued complaints of pain in the left shoulder and neck area. The patient has been recommended for 6 individual psychotherapy session, and 6 health and behavior intervention sessions to address pain related to the compensable work injury via biofeedback training.

Requested Services

6 individual psychotherapy sessions and health and behavior intervention via biofeedback training.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Medical Dispute Resolution Position Letter (no date)
2. Clinical Interview 11/15/04
3. Initial Narrative 1/19/04
4. Office Notes 9/6/04
5. Clinical Interview 11/15/04

Documents Submitted by Respondent:

1. Summary of Carrier's Position 2/4/05
2. ASC Detail Notes 9/6/03, 8/18/03, 6/24/03
3. Psychological Consultation 7/15/03

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 male who sustained a work related injury on ___. The MAXIMUS physician reviewer indicated that the patient underwent a cervical fusion in 5/2004, has been treated with medications, physical therapy and rehabilitative therapy, and has continued complaints of pain. The MAXIMUS physician reviewer also indicated that the patient has been psychologically evaluated. The MAXIMUS physician reviewer noted that the patient has been diagnosed with depression and anxiety and was found to be angry and frustrated with his current condition. The MAXIMUS physician reviewer indicated that the patient has not benefited appropriately from 16 1 on 1 physician conducted psychotherapy sessions. The MAXIMUS physician reviewer explained that this patient is suffering from more than pain secondary to his work related injury. The MAXIMUS physician reviewer indicated that behavioral interventions are required to assist this patient in healing. The MAXIMUS physician reviewer explained that focused behavior modification and biofeedback can be effective in treating this patient's current condition. Therefore, the MAXIMUS physician consultant concluded that the requested 6 individual psychotherapy sessions and health and behavior intervention via biofeedback training are 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 14th day of March 2005.

Signature of IRO Employee: _____
External Appeals Department