

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER: 453-05-7677.M2

May 26, 2005

VIA FACSIMILE
Szygy Associates.
Attn: L. Kinney

VIA FACSIMILE
Zurich American
C/o FOL.
Attn: Kelly Pinson

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-1579-01
TWCC #: ____
Injured Employee: ____
Requestor: Szygy Associates
Respondent: Zurich American c/o FOL
MAXIMUS Case #: TW05-0096

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 female who sustained a work related injury on _____. The patient reported that while at work she injured her back when she transferred a patient from one bed to another. An MRI of the lumbar spine performed on 5/2/03 was reported to be negative. A lumbar

myelogram performed on 5/25/04 revealed a normal lumbar myelogram and CT scan of the lumbar spine. A lumbar discogram performed on 6/17/04 revealed a normal discogram. The diagnoses for this patient have included lumbar intervertebral disc without myelopathy and neuralgia, neuritis, and radiculitis, unspecified. Treatment for this patient's condition has included chiropractic adjustments and physical therapy, electrical stimulation, heat and ice, TENS, and massage. The patient has been recommended for psychotherapy and health & behavioral intervention once a week for 6 weeks for further treatment of her condition.

Requested Services

Psychotherapy once a week for 6 weeks, health & behavioral intervention once a week for 6 weeks.

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

Documents Submitted by Requestor:

1. No documents submitted

Documents Submitted by Respondent:

1. FCE 2/16/04, 10/27/04
2. Clinical Interview 7/22/04
3. Designated Doctor's Evaluation 9/9/04, 7/1/04, 2/16/04
4. Behavioral Medicine Assessment 8/25/04
5. Lumbar Spine Myelogram report 5/25/04
6. Discogram Report 6/17/04

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 47 year-old female who sustained a work related injury to her back on _____. The MAXIMUS physician reviewer indicated that this patient has a two-year history of consistent lumbosacral pain secondary to a probable mild soft tissue injury sustained on _____. The MAXIMUS physician reviewer noted that the patient's pain is rated a 6/10 and has been refractory to all standard conservative treatment. The MAXIMUS physician reviewer also noted that the diagnostic testing this patient has undergone was reported to be negative, that the patient has no myelopathy or radiculopathy and that she is not a surgical candidate. The MAXIMUS physician reviewer indicated that the patient continues to use pain medication and that her pain levels remain moderate, that the patient reports that her life has been profoundly altered and that she is unable to work.

The MAXIMUS physician reviewer explained that this is a patient with a major psychogenic and regressive Axis II character pathology assuring the chronicity of this patient's pain as well as the development of increased depression and drug dependency. The MAXIMUS physician reviewer indicated that this patient requires modification of her behavior to examine possible

contributing emotional factors for her chronic pain. The MAXIMUS physician reviewer noted explained that a multitude of situational and familial, past historical events could have altered her threshold for pain. The MAXIMUS physician reviewer noted that the documentation provided failed to demonstrate that these possibilities have been addressed in previous treatment. (American Psychiatric Disorders; 2002). Therefore, the MAXIMUS physician consultant has concluded that the requested Psychotherapy once a week for 6 weeks, health & behavioral intervention once a week for 6 weeks 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 26th day of May 2005.