

June 1, 2005

Re: MDR #: M2-05-1626-01 **Injured Employee:**
TWCC#: **DOI:**
IRO Cert. #: 5055 **SS#:**

TRANSMITTED VIA FAX TO:
Texas Workers' Compensation Commission
Attention:
Medical Dispute Resolution
Fax: (512) 804-4868

REQUESTOR:
Active Behavioral Health
Attention: James Odom
(214) 692-6670

RESPONDENT:
American Home Assurance Co.
Attention: Annette Moffett
(512) 867-1733

TREATING DOCTOR:
Luz Gonzalez, DC
(817) 336-0249

Dear Ms. ____

:

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI 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 Independent Review, Inc. 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 licensed psychologist, specializing in pain management, and is currently listed on the TWCC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by Independent Review, Inc. 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 June 1, 2005.

Sincerely,

Gilbert Prud'homme
General Counsel

GP/th

REVIEWER'S REPORT
M2-05-1626-01

Information Provided for Review:

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

Information from Requestor:

Correspondence and office note of 01/26/05

Information from Respondent:

Correspondence and designated doctor review

Information from Treating Doctor:

Office notes 09/13/04 – 04/15/05

FCE's 10/19/04 – 03/10/05

ERGOs test 01/06/05

Information from Pain Management Specialist:

Office notes 08/12/04 – 09/30/04

Information from General Surgeon:

Office notes 08/30/04 – 09/21/04

Radiology report 09/02/04

Clinical History:

This female patient injured her back at work on _____. She developed chronic pain, depression, and anxiety. She presents with documented common psychological consequences of chronic pain, specifically including depression and anxiety. Physical examinations have documented muscle spasms and reduced range of motion, which are objective findings.

Disputed Services:

Individual psychotherapy 1 X 6, biofeedback psychophysiological profile assessment, and biofeedback therapy 1 X 6.

Decision:

The reviewer partially agrees with the determination of the insurance carrier as follows:

Medically Necessary: individual psychotherapy 1 X 6

Biofeedback psychophysiological profile assessment

Not Medically Necessary: biofeedback therapy 1 X 6

Rationale:

Debilitating pain can occur in the absence of detectable structural damage or harm. Individual psychotherapy 1 X 6 appears indicated as necessary for treatment of the patient's chronic pain, depression, and anxiety. Biofeedback psychophysiological profile assessment appears medically necessary based on the patient's condition. Biofeedback therapy may be needed, but should await the outcome of the biofeedback PPA to determine whether biofeedback therapy is, in fact, needed.