

June 28, 2005

VIA FACSIMILE  
Injury One Treatment Center  
Attn: James Odom

VIA FACSIMILE  
Zurich c/o FOL  
Attn: Katie Foster

### NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M2-05-1670-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor: Injury One Treatment Center**  
**Respondent: Zurich American Insurance Company c/o FOL**  
**MAXIMUS Case #: TW05-0110**

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 to his back and head on \_\_\_\_\_. The patient reported injury occurred while he was working under a hood of a car in a parking lot. He noted that another car backed into him forcing him into the hood of the first car. He complained of pain the lumbar spine and radiating to the legs. The patient was diagnosed with injury related depression, low back pain, lumbosacral radiculopathy, L3-4 disc desiccation, cervicalgia and cervical radiculopathy. Treatment has included chiropractic care, physical

therapy, medication, injections, and surgery to the cervical and lumbar spine. The patient is experiencing persistent pain. Individual psychotherapy for 1-4 weeks was recommended for treatment of his condition.

### Requested Services

Individual psychotherapy for 1-4 weeks.

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

#### *Documents Submitted by Requestor:*

1. Behavioral Health Treatment Request - 2/25/05
2. Request for Behavioral Health Treatment - 3/21/05
3. Individual Psychotherapy Plans & Goals of Treatment - 2/25/05, 3/21/05
4. Work hardening progress note – not dated
5. Physical Status Update 3/17/05
6. Non-authorization Notice After Reconsideration Notice – 3/30/05
7. Initial Behavioral Medicine Consultation – 1/16/05
8. Cervical MRI - 7/19/04
9. Operative Notes – 11/13/03, 9/15/04
10. Post Discography CT Imaging of Lumbar Spine – 9/4/03
11. Provocative Pain Testing with Lumbar Discography – 9/4/03
12. Cervical Epidural Injection Report – 6/29/05
13. Radiologic Review – not dated
14. Neurosurgery follow-up – 8/17/04
15. Discharge Summary – 11/13/03
16. Radiology Report – 8/24/03, 8/25/03, 11/13/03, 12/19/03, 7/9/04, 8/30/04, 7/19/04, 9/15/04
17. Pathology Report – 11/14/05
18. Neurosurgery Office Notes – 8/15/03-9/28/04

#### *Documents Submitted by Respondent:*

1. Work Hardening Daily Notes – 1/24/05-3/8/05
2. Group Notes – 1/31/05, 2/7/05, 2/9/05, 2/17/05, 2/18/05, 3/3/05
3. Initial Functional Capacity Evaluation – 12/28/04
4. Interim Functional Capacity Evaluation – 2/28/05
5. Physical Therapy Re-evaluations – 2/28/05, 3/8/05
6. Work Hardening Program - 2/7/05
7. Work Hardening Daily Flow Sheets – 1/24/05-3/11/05
8. Interdisciplinary Group Therapy Notes – 2/25/05, 2/28/05, 3/2/05
9. Psychotherapy Group Notes – 1/25/05, 2/8/05, 3/8/05
10. Initial Behavioral Medicine Consultation – 1/6/05
11. Subsequent Medical Narrative Report – 1/4/05
12. Hospital records – 3/12/04-3/15/04

## 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 male who sustained a work related injury to his back and head on \_\_\_\_\_. The MAXIMUS physician reviewer also noted that the patient developed lumbarsacral and cervical radiculopathy and persistent moderate levels of pain requiring hydrocodone, which was resistant and refractory to a variety of conservative and chiropractic treatments. The MAXIMUS physician reviewer further noted that he also developed severe depression and moderate anxiety secondary to this injury and related inability to return to work, financial worries, poor sleep and on-going pain. The MAXIMUS physician reviewer indicated that an evaluation and psychological testing led to a recommendation for one on one psychiatric treatment of 1-4 weeks duration centering around cognitive-behavioral and stress reducing approaches. The MAXIMUS physician reviewer noted that this patient is an excellent candidate for potential benefit and symptom reduction with a combined cognitive, behavioral and psychopharmacologic approach to his condition. The MAXIMUS physician reviewer explained that this combined therapy would assist him in future stress management and planning to cope with his life changes since his injury. Therefore, the MAXIMUS physician consultant concluded that the requested Individual psychotherapy for 1-4 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**

Lisa Gebbie, MS, RN  
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 28th day of June 2005.

Signature of IRO Employee: \_\_\_\_\_  
External Appeals Department