

July 6, 2005

VIA FACSIMILE  
Mr. Nick Kempisty  
Canton Healthcare Systems

VIA FACSIMILE  
Mr. Robert Josey  
City of Dallas

### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M2-05-1836-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent: City of Dallas**  
**MAXIMUS Case #: TW05-0118**

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 51 year-old male who sustained a work related injury to his hand, ribs and back on \_\_\_\_\_. He also sustained a work related injury to his neck on \_\_\_\_\_. He has been diagnosed with a herniated disc and anxiety disorder due to a general medical condition resulting from his \_\_\_\_\_ work injury. His complaints include low back pain, neck pain, leg pain, moderate depression and anxiety. The report from a MRI of the patient's lumbar spine performed on 4/2/04 indicated that the impression was mild facet joint hypertrophy at all levels,

mild to moderate facet joint arthroplasty at L5-S1, mild generalized disc bulging at L3-4 and L4-5, and no evidence of a lumbar disc herniation or nerve root compression. The report from a 3 level lumbar discogram and post-discogram CT performed on 5/6/04 indicated that the patient experienced concordant low back pain during the injection of L4-5 and that abnormal disc morphology with a posterior annular fissure and posterior epidural extravastion was noted at this level. It also indicated that the injection at L3-4 was clinically negative and that nuclear morphology appeared normal at that level. The patient has been treated with several injections, medications, and therapy. The patient's medications in March 2005 included Hydrocodone, Avinza, Neurotin, Flexeril, Xanax and Zoloft. Referral to a chronic pain management program has been recommended for this patient.

### Requested Services

10 sessions of chronic behavioral pain management.

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

#### *Documents Submitted by Requestor:*

1. Letter dated 6/12/05
2. Initial medical evaluation dated 3/10/05
3. Physical performance examination, functional capacity evaluation summary, computerized spinal range of motion examination, lift task exam, grip exam, sustained grip exam, pinch exam, impairment summaries and exam summary reports dated 3/15/05
4. Evaluation report dated 3/15/05
5. Request for reconsideration dated 4/11/05

#### *Documents Submitted by Respondent:*

1. Pre-authorization reports and notifications dated 4/4/05 and 4/15/05
2. Report from a three level lumbar discogram and post discogram CT scan performed on 5/6/04
3. Report from a MRI scan without contrast – lumbar spine performed on 4/2/04
4. Report from EEG, EMG and evoked potential testing performed on 4/6/04
5. Report from a CT scan of the lumbar spine performed on 8/12/03
6. Report from a MRI of the lumbar spine performed in June 2002
7. Required Medical Examination Report

### 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 51 year-old who sustained a work related injuries resulting in chronic low back, neck and bilateral leg pain. The MAXIMUS

physician reviewer indicated that he has depression and anxiety associated with his chronic pain. The MAXIMUS physician reviewer also indicated that he has done poorly for 4 years. The MAXIMUS physician reviewer explained that although the patient received one psychological evaluation, he has not received a more detailed evaluation, psychiatric consultation or a significant trial of medications for his depression and anxiety. The MAXIMUS physician reviewer noted that the patient's medications have included Zoloft, Xanax, Flexeril and Neurontin. The MAXIMUS physician reviewer indicated that the pharmacotherapy this patient has received for his condition has not been adequate. The MAXIMUS physician reviewer explained that while a trial of individual care with a psychiatrist and a new medication regimen may be beneficial for the patient in some ways, this treatment approach is unlikely to proven successful for treatment of his chronic pain condition. The MAXIMUS physician reviewer also explained that the patient would likely benefit from a participation in a chronic pain management program with a strong didactic and cognitive behavioral approach. (American Psychiatric Association, Treatment of Psychiatric Disorders, 2002.) Therefore, the MAXIMUS physician consultant concluded that 10 sessions of chronic behavioral pain management 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 K. Maguire, Esq.  
Project Manager, State Appeals

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 6<sup>th</sup> day of July 2005.

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