

# MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

Phone: 512-402-1400

FAX: 512-402-1012

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-1899-01
Name of Patient:	
Name of URA/Payer:	Old Republic Insurance
Name of Provider: (ER, Hospital, or Other Facility)	Active Behavioral Health & Pain Rehab
Name of Physician: (Treating or Requesting)	Marivel Subia, DC

July 11, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in psychiatry. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD  
Medical Director

cc: Active Behavioral Health & Pain Rehab  
Marivel Subia, DC  
Texas Workers Compensation Commission

#### CLINICAL HISTORY

This 47-year-old Hispanic male sustained a thoracic spine injury in \_\_\_\_ while working as a forklift driver. He was pulling 150 pound metal sheets side to side which caused his injury. He had worked for this company for two years. He attempted to continue working for a few days and then sought treatment.

The patient was first tried with conservative treatment including passive therapy, physical therapy, 2 week hardening program and low-level behavioral healthcare. He failed these modalities and was then placed in a 30-day interdisciplinary rehabilitation program which was completed on 4/4/05. He was very compliant with treatment and had full participation. He was in the process of trying to return to work and was recommended for 6 weeks of outpatient therapy and biofeedback to help re-integrate him back to work and deal with his limitations from his injury.

The patient began treatment for depression and anxiety in September 2004. He had neurovegetative symptoms of depression including insomnia, decreased appetite, weight loss, decreased energy, impaired memory and concentration. He was also extremely anxious, irritable, had increased anger and mood swings. In December 2004 he was started on Zoloft 25mg. He was originally diagnosed with Adjustment Disorder.

#### REQUESTED SERVICE(S)

Biofeedback therapy 1x week x 6 weeks.

#### DECISION

Reverse prior denial. Approve.

### RATIONALE/BASIS FOR DECISION

The patient attempted conservative treatment, failed and then was successful with more intensive treatment. He was cooperative and compliant. He developed symptoms of depression and anxiety that actually met the criteria for major depressive episode. He was started on an antidepressant which should be used for a minimum of 12 months. After his 1 month intensive treatment, it is medically appropriate and necessary to have outpatient follow-up. 6 weeks of outpatient therapy is less than standard of care to help this patient achieve remission of his depression and anxiety disorder; it is usually 6 psychotherapy sessions and biofeedback as well as followed monthly for antidepressant treatment. It appears this patient plans to go back to work and his support structure that has been recommended is medically sound.

## 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) calendar days of your receipt of this decision (20 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 **20** (twenty) calendar 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 or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), 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 7<sup>th</sup> day of July 2005.

Signature of IRO Employee: \_\_\_\_\_

Printed Name of IRO Employee: Cindy Mitchell