

August 18, 2005

VIA FACSIMILE
Michael Anderson, DC
Attn: Marzia

VIA FACSIMILE
Service Lloyds Insurance Company c/o Harris & Harris
Attn: Robert Josey

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-1975-01
TWCC #:
Injured Employee:
Requestor: Michael Anderson, DC
Respondent: Service Lloyds Insurance Company c/o Harris & Harris
MAXIMUS Case #: TW05-0131

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 on _____. He has been diagnosed with displacement of cervical disc without myelopathy, displacement lumbar disc without myelopathy, muscle spasm, pain disorder associated with psychological factors and injury related medical condition, depressive disorder associated with work related injury – mild. The patient has been treated with medications, physical therapy, cervical epidural steroid injections, 2 cervical surgical procedures involving fusion of C5-6 in May 2003 and revision of

the fusion in April 2004. Participation in a chronic pain management program has been recommended for further treatment of this patient's condition.

Requested Services

Individual psychotherapy X 4 sessions.

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

Documents Submitted by Requestor:

1. Letter of medical necessity dated 6/28/05
2. Records from the treating doctor dated 10/7/04
3. Letter from the treating doctor dated 3/2/05
4. Report from a functional capacity examination performed on 10/5/04
5. Behavioral Health Assessment Report dated 4/7/05
6. Evaluation report dated 10/1/04
7. Medical records from 2/6/03 to 6/22/05
8. Operative reports dated 5/7/03 and 4/28/04
9. Records from the prior treating doctor from 8/21/02 to 1/8/03
10. Report of MRI of the cervical spine performed on 6/11/02
11. Report of MRI of the thoracic spine performed on 12/26/02
12. Report of MRI of the lumbar spine performed on 12/26/02
13. EMG reports dated 8/28/02 and 10/7/04

Documents Submitted by Respondent:

1. Cover letter dated 7/1/05
2. Medical Necessity Evaluation Report dated 4/21/05
3. Denial letters dated 10/19/04, 4/7/05, 4/26/05, 5/6/05, 5/11/05, 5/12/05 and one undated letter
4. Letter regarding records review dated 10/25/04
5. Physician consultant review dated 12/7/04
6. Letters regarding requested physician review dated 1/18/05 and 5/3/05
7. Report from EMGs performed on 8/28/02 and 10/7/04
8. Report from cervical myelogram with post myelogram CT performed on 2/3/04
9. Report from MRI of the thoracic spine performed on 12/26/02
10. Report from MRI of the lumbar spine performed on 12/26/02
11. Letter regarding required medical examination dated 1/20/02

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The MAXIMUS physician reviewer indicated that this 51-year old male with C5 and C6 spinal fusion after a work related injury and a possible lumbar disc component. The MAXIMUS physician reviewer also indicated that the patient failed to obtain pain relief from his cervical

fusion and is refractory to all other rehabilitation attempts including chiropractic services, injections and medications. The MAXIMUS physician reviewer further indicated that this patient remains in chronic pain. MAXIMUS physician reviewer noted he now has major decompensation in several areas. MAXIMUS physician reviewer also indicated the member is not on antidepressant medication. MAXIMUS physician reviewer noted that this patient continues to require strong support and structured psychological care to reduce his chronic pain and depression that is a psychological component to this illness. (American Psychiatric Association Compendium Guidelines to the Treatment of Psychiatric Disorders, 2002)

Therefore, the MAXIMUS physician consultant concluded that the requested individual psychotherapy X 4 sessions are medically necessary for treatment of this patient's condition.

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 18th day of August 2005.

Signature of IRO Employee: _____
External Appeals Department