

August 9, 2005

VIA FACSIMILE
Positive Pain Management
Attn: Helena

VIA FACSIMILE
Ms. Jeanne Schafer
Travelers Indemnity Company

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-05-2000-01
TWCC #:
Injured Employee:
Requestor: Positive Pain Management
Respondent: Travelers Indemnity Co.
MAXIMUS Case #: TW05-0136

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 22 year-old male who sustained a work related injury to his left foot on _____. In December 2000, he underwent open reduction internal fixation of a left ankle fracture. He also underwent a second ankle surgery in September 2001, removal of hardware and repair of nonunion in May 2002, bone stimulation implantation in October 2002, surgical resection of bone graft and stimulator placement in December 2003, repair of internal fixation after a new fall injury in _____ and hardware removal and battery insertion in July 2004. The patient has also been treated with skin graft procedures, active and passive physical therapy, individual

psychotherapy, biofeedback, medications and a 30 day pain management program in 2003. The patient has been diagnosed with status post fusion of the left foot, neuritis of the left foot, depressive disorder not otherwise specified and pain disorders related to psychological factors, other, chronic. Ten sessions of a pain management program were approved for him and completed on 6/10/05. Authorization for an additional ten sessions has been requested.

Requested Services

10 sessions of chronic pain management.

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

Documents Submitted by Requestor:

1. None submitted

Documents Submitted by Respondent:

1. MDR letter dated 6/1/05
2. Denial letters dated 5/10/05 and 5/27/05
3. Negotiated approval letter dated 4/22/05
4. Summary of Biofeedback Treatment and Request for Aftercare Treatment dated 6/10/05
5. Request for Appeal dated 5/18/05
6. Psychological evaluation report dated 3/17/05
7. Psychophysiological assessment report
8. Initial examination report dated 3/17/05
9. Individualized treatment plan dated 3/17/04
10. Referral for evaluation and treatment by a chronic pain management program dated 1/6/05

Decision

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

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a 22 year-old male who sustained work related injury to his left foot on _____. The MAXIMUS physician reviewer indicated that this patient undergone treatment for this condition for 2 years. The MAXIMUS physician reviewer also indicated that he received 10 sessions of chronic pain management services in the spring of 2005. The MAXIMUS physician reviewer explained that although the patient has been diagnosed with depressive disorder not otherwise specified and had a markedly elevated Beck Depression Index score, he was not on antidepressant medications. The MAXIMUS physician review also explained that it appears that one of the goals of the chronic pain management treatment he received was to reduce the use of controlled substances, but that Hydrocodone was prescribed for the patient. The MAXIMUS physician reviewer indicated that

the literature does not demonstrate that a repeat program of chronic pain management is likely to be effective for treatment of this patient's condition. Therefore, the MAXIMUS physician consultant concluded that requested 10 sessions of chronic pain management are not 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 9th day of August 2005.

Signature of IRO Employee:

External Appeals Department