



7600 Chevy Chase, Suite 400  
Austin, Texas 78752  
Phone: (512) 371-8100  
Fax: (800) 580-3123

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** August 23, 2005

**Requester/ Respondent Address:**

TWCC  
Attention: Rebecca Farless  
7551 Metro Center Drive, Suite 100, MS-48  
Austin, TX 78744-1609

Dr. Trenton Weeks  
Attn: Rhonda  
Fax: 972-613-4335  
Phone: 972-613-4334

Hartford Ins Co  
Attn: Barbara Sachse  
Fax: 512-343-6836  
Phone: 512-343-8310

**RE: Injured Worker:**

**MDR Tracking #:** M2-05-2094-01  
**IRO Certificate #:** IRO 5263

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Psychiatric reviewer (who is board certified in Psychiatry) who has an ADL certification. The physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### **Submitted by Requester:**

- Notification of IRO assignment
- Letter from the claimant
- Non-authorization letters
- Treatment notes from Dr. Weeks, Dr. Milani, Dr. Banta
- Operative reports
- MRIs of the lumbar spine
- Narrative of requested treatment from Dr. Rosado
- Mental health evaluation from Dr. Rosado
- Treatment notes and operative reports from Dr. Rowlan

### **Submitted by Respondent:**

- Notice of IRO assignment
- Documentation as previously cited from Dr. Rosado
- Letters of non-authorization
- Treatment note from Dr. Russell
- Treatment notes from Dr. Rowlan
- MRIs of the lumbar spine
- Physical therapy notes
- Work status reports
- Treatment and operative report from Dr. Milani
- Internal medicine consult
- Treatment notes from Dr. Banta
- Treatment notes from Dr. Weeks
- Physical therapy notes

### **Clinical History**

The claimant was injured in the course of his duties while lifting a desk. This resulted in injury to the lumbar spine. He has subsequently undergone conservative treatment measures as well as 2 surgeries. During the time period of May through June 2005, he was reporting to Dr. Weeks significant anxiety and depression. Dr. Weeks notes marital problems, psychosocial problems, and family issues. The specifics of these are not detailed. Dr. Weeks referred the claimant to Dr. Rosado. Dr. Rosado diagnosed the claimant with a pain disorder and recommended a course of 8 individual therapy sessions. There were non-authorized. Around this same time period, Dr. Weeks also referred the claimant to Dr. Milani for further evaluation. Dr. Milani felt that a third lumbar surgery was indicated, and the claimant had this in June 2005.

### **Requested Service(s)**

Individual psychotherapy sessions once per week for 8 weeks

## **Decision**

I disagree with the carrier and find that 4 of the 8 sessions of individual psychotherapy are medically necessary.

## **Rationale/Basis for Decision**

This decision is based solely upon medical necessity criteria and not upon relatedness to the injury. I would note that the documentation indicates family and psychosocial issues that are contributing to the claimant's mood and anxiety complaints, and none of the providers have fully outlined the nature of these issues and to what extent they can be attributed to the injury. However, there is adequate documentation to support the claimant as having anxiety and depression symptoms that would likely benefit from some individual therapy. I do agree with the carrier that the proposed treatment plan was expansive in that a large portion of it was directed towards approaching chronic pain symptoms; however, a substantial portion of it was addressed at addressing mood, anxiety and anger control problems. It is for these issues and not the pain itself that I would recommend a trial of individual therapy. Given the duration of the pain complaints and the fact that further lower level interventions were planned for this claimant, the likelihood of unimodal pain management techniques substantially helping this claimant's pain is low. Again, overall, I recommend authorization of 4 of the sessions to be directed primarily at the mood and anxiety complaints with consideration for additional sessions if there is evidence that the claimant is actively participating in and making substantive gains with the treatment.

## **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 (28 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) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744

Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this 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 patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 23<sup>rd</sup> day of August 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder