

IRO America Inc.
An Independent Review Organization
7626 Parkview Circle
Austin, TX 78731
Phone : 512-346-5040
Fax: 512-692-2924

facsimile transmittal

To: Fax: 512-804-4868
From: IRO America Date: 3/27/2008
Re: Final Decision Letter Pages: 6
Cc:

Urgent For review Please Please reply Please recycle

IRO America Inc.

An Independent Review Organization

7626 Parkview Circle

Austin, TX 78731

Phone: 512-346-5040

Fax: 512-692-2924

March 3, 2006

TDI-DWC Medical Dispute Resolution

Fax: (512) 804-4868

Patient: _____
TDI-DWC #: _____
MDR Tracking #: M2-06-0667-01
IRO #: 5251

IRO America Inc. (IRO America) has been certified by the Texas Department of Insurance as an Independent Review Organization. The TDI, Division of Workers' Compensation (DWC) has assigned this case to IRO America for independent review in accordance with DWC Rule 133.308 which allows for medical dispute resolution by an IRO.

IRO America has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor; the Reviewer is a credentialed Panel Member of IRO America's Medical Knowledge Panel who is a licensed Provider, board certified and specialized in Psychology. The reviewer is on the DWC Approved Doctor List (ADL).

The IRO America Panel Member/Reviewer is a health care professional who has signed a certification statement stating that no known conflicts of interest exist between the Reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carriers health care providers who reviewed the case for decision before referral to IRO America for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

RECORDS REVIEWED

Notification of IRO Assignment, records from the Requestor, Respondent, and Treating Doctor(s), including:

- Behavioral Medicine Testing Results, 6/28/05, Jeanne Selby, Ph.D. & Nicole Mangum, Ph.D.
- Dallas Spine Care, Chart Note, 10/10, 2005, Robert J. Henderson, M.D.
- DFW MRI, 4/23/2005, Eric S. Bennos, M.D.
- Prime Diagnostic Imaging, 3/30/04, Marc Berger, M.D., P.A.

CLINICAL HISTORY

The Patient is a truck driver/delivery worker who sustained an injury on _____ to his lower back while loading 120 pound cylinders into the back of a truck. During the loading process, the cylinders began to fall, The Patient turned sideways to circumvent the fall and twisted his back. The Patient reported feeling a sharp, burning pain in his lower back that worsened over the course of 2 subsequent days of work. The Patient sought care by the company physician, Dr. Rainwater, was given medication and physical therapy, did not work for 2 weeks, and then returned to work on light duty. On 3/29/04, Marc Berger, M.D., P.A. performed structural MRI on The Patient, which revealed “two abnormal discs, one at L1-L2 with approximately 1 mm sized disc protrusion and the more significant abnormal disc is at L4-L5, a 2 to 3 mm sized central to slightly right central disc protrusion with HIZ indicative of a posterior annular tear just to the right of midline. The Patient continued to work light duty for 1-2 months, but felt unable to work and was sent to Dr. Rainwater. The Patient underwent an EMG/NCV on 7/12/04 that showed no abnormalities. The Patient was referred to a pain management specialist and given 2 epidural steroid injections and 1 trigger point injection (08/04). The Patient began physical rehabilitation with Dr. Henderson on 3/3/05. The Patient underwent “anterior disc replacement, interbody fusion, and interbody fixation at L4-L5 and L5-S1, transverse process fusion L4-S1 with segmental pedicle fixation, and the use of bone graft” on 8/25/2005. In October 2005, Dr. Botefuhr asked for an evaluation of The Patient’s post-surgical psychological condition. The Patient endorses average daily pain as 5-9/10 with intermittent elevations to a 10/10 after the surgery. The level of interference this pain has on normal activities is rated by The Patient as 3/10. The Patient reports the level of interference with his normal activities and ability to work as 10/10. The Patient reports experiencing significant lifestyle changes (difficulty with self grooming, household chores, driving; negative changes in significant relationships, social isolation and symptoms indicative of major depressive disorder (e.g., sleep disturbances; weight loss, insomnia nearly every day, fatigue/loss of energy, and diminished ability to think or concentrate).

DISPUTED SERVICE(S)

Under dispute is the prospective, and/or concurrent medical necessity of individual psychotherapy, 1 time a week for 6 weeks.

DETERMINATION/DECISION

The Reviewer disagrees with the determination of the insurance company.

RATIONALE/BASIS FOR THE DECISION

The Patient has been diagnosed with:

Axis I: 296.22, Major Depressive Disorder, single episode, moderate.

307.89, Pain Disorder Associate with Both Psychological Factors and a General Medical Condition.

The work accident, chronic pain, and ensuing functional limitations have caused this patient’s disruption in lifestyle, leading to the above diagnosis. The Patient was functioning successfully prior to the injury sustained on 3/23/04.

Pain has been consistently identified as a condition that negatively impacts patient recovery. This Patient is experiencing post-surgical emotional distress and pain. The treatment of choice proposed is behavioral health interventions and is consistent with standards of practice. It has been accepted for over a decade that a number of well-defined behavioral interventions are effective in the treatment of protracted, chronic pain.^{1, 2} The biopsychosocial program proposed

by Texas Health for treating this patient is as medically necessary as the other treatments The Patient has received for his injury. Of six factors identified to correlate with treatment failures of low back pain, all are psychosocial.⁴ This Patient was recommended for behavioral medicine by his treating physician because conventional and accepted means of “physical” pain management have not allowed him to experience relief from his pain and emotional distress.

It has been determined by his mental health care professionals that a specified course of psychological intervention should give him some pain relief and a better outlook on his future,³ with the ultimate goal a return to his prior level of functioning (e.g., the ability to work). The Patient’s mental health care provider is requesting 6 IPT sessions to satisfy rule TWCC 134.1001(C)(1)(A) on Entitlement to Medical Benefits stating “An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.” The Reviewer agrees with The Patient’s mental health care provider.

Screening Criteria

1. Specific:

(1) Magni, G., Marchetti, M., Moreschi, C., Merskey, H., Luchini, S.R. (1993). Chronic musculoskeletal pain and depressive symptoms in the national health and nutrition examination. I. Epidemiologic follow-up study. *Pain*, 53: 163-8.

² Astin, J. A., Shapiro, S.L., Eisenberg, D.M., Forsy, K.L. (2003). Mind-body medicine; state of the science, implications for practice. *J Am Board Fam Pract*, 16, 131-147.

³ Rainville, P. (2002). Brain mechanisms of pain affect and pain modulation. *Curr Opin Neurol*, 12, 195-204

⁴ Morley, s., Eccleston, C., Williams, A. (1999). Systematic review and meta-analysis of randomized controlled trials of cognitive behavior therapy and behavior therapy for chronic pain in adults, excluding headache. *Pain*, 80, 1-13.

2. General:

In making his determination, the Reviewer had reviewed medically acceptable screening criteria relevant to the case, which may include but is not limited to any of the following: Evidence Based Medicine Guidelines (Helsinki, Finland); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Texas Chiropractic Association: Texas Guidelines to Quality Assurance (Austin Texas); Texas Medical Foundation: Screening Criteria Manual (Austin, Texas); Mercy Center Guidelines of Quality Assurance; any and all guidelines issued by DWC or other State of Texas Agencies; standards contained in Medicare Coverage Database; ACOEM Guidelines; peer-reviewed literature and scientific studies that meet nationally recognized standards; standard references compendia; and findings; studies conducted under the auspices of federal government agencies and research institutes; the findings of any national board recognized by the National Institutes of Health; peer reviewed abstracts submitted for presentation at major medical associates meetings; any other recognized authorities and systems of evaluation that are relevant.

CERTIFICATION BY OFFICER

IRO America has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. IRO America has made no determinations regarding benefits available under the injured employee’s policy.

As an officer of IRO America Inc., I certify that there is no known conflict between the Reviewer, IRO America and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

IRO America is forwarding by mail or facsimile, a copy of this finding to the DWC, the Injured Employee, the Respondent, the Requestor, and the Treating Doctor.

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer

Cc: _____

Texas Health
Attn: James Odom
Fax: 214-692-6670

Zurich American Ins
Attn: Katie Foster
Fax: 512-867-1733

John Botefuhr, D.C.
Fax: 214-368-5656

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

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

I hereby certify, in accordance with DWC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the DWC via facsimile, U.S. Postal Service or both on this 22th day of November, 2005.

Name and Signature of IRO America Representative:

Sincerely,
IRO America Inc.

Dr. Roger Glenn Brown
President & Chief Resolutions Officer