



PROFESSIONAL ASSOCIATES

NOTICE OF INDEPENDENT REVIEW

NAME OF PATIENT: _____
IRO CASE NUMBER: M2-06-0065-01
NAME OF REQUESTOR: _____
NAME OF PROVIDER: Stuart Meyers, D.C.
REVIEWED BY: Board Certified in Psychiatry
Board Certified in Neurology in Psychiatry
Board Certified in Pain Medicine
IRO CERTIFICATION NO: IRO 5288
DATE OF REPORT: 11/03/05

Dear Ms. ____:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed 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. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Psychiatry, Neurology in Psychiatry, and Pain Medicine and is currently listed on the DWC Approved Doctor List.

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I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the provider, 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 carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization.

REVIEWER REPORT

Information Provided for Review:

An evaluation dated 07/12/05 at Medical Biofeedback and Pain Control Center by Jack R. Scherschell, Ph.D.

A Clinical Interview and Polinsky Psychosocial Screening Inventory dated 07/14/05 from Dr. Scherschell

An evaluation dated 07/19/05 from Jacob Liebman, M.D. from Medical Biofeedback and Pain Control Center

Notes from Linda Beachley, L.V.N. dated 07/29/05 and 08/17/05

An adverse determination for the 12 sessions of individual counseling and biofeedback from St. Paul Travelers signed by Ms. Beachley dated 08/17/05

A letter "To Whom It May Concern" dated 09/20/05 from Dr. Liebman and Dr. Scherschell

Clinical History Summarized:

On 07/12/05, Dr. Scherschell evaluated the patient on 07/12/05 and he felt the patient was a good candidate for non-invasive pain and stress management that would include biofeedback and counseling. Dr. Scherschell performed a Clinical Interview and a Polinsky Psychosocial Screening Inventory on 07/14/05. He recommended biofeedback and individual psychotherapy. On 07/19/05, Dr. Liebman evaluated the patient and felt she had a lumbosacral sprain/strain with spasms. He also recommended biofeedback and counseling. Ms. Beachley noted on 07/29/05 an adverse determination was provided for the 12 sessions of individual psychotherapy and biofeedback. On 08/17/05, Ms. Beachley provided another adverse determination for the 12 sessions of biofeedback and counseling sessions. Dr. Scherschell and Dr. Liebman provided a letter "To Whom It May Concern" regarding the effectiveness of biofeedback and counseling treatment for the patient. They recommended the treatment be approved as soon as possible.

Disputed Services:

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Twelve sessions of biofeedback and 12 sessions of counseling

Decision:

I disagree with the requestor. The 12 sessions of biofeedback and the 12 sessions of counseling are neither reasonable nor necessary.

Rationale/Basis for Decision:

The patient has a preexisting psychiatric condition. In reasonable medical probability, the development of a "major depressive disorder" would not be related to a lumbar sprain/strain. Furthermore, optimal treatment guidelines for major depression is psychotherapy and medication management. Medical necessity for 12 individual psychotherapy sessions and 12 biofeedback sessions in the context of this workers compensation injury cannot be established.

CRITERIA USED: American College of Occupational and Environmental Guidelines (ACOEM) chapter 6, page 107, reads: "The immediate focus should be on functional improvement rather than on abolishing pain. Physicians should be aware that while complete cessation of pain may not be a realistic goal for some patients, self-care, functional restoration, and successful reintegration into the workforce can be attainable goals even though the complete elimination of pain may not be possible." There are many dimensions to pain. A major dimension of chronic pain complaints is fear avoidance as a result of a fear of reinjury. Pain related to fear avoidance models typically describe these chronic pain patients as perpetuating disability. ACOEM chapter 6, page 113 reads, "Exposing patients to activities they fear as a way to reduce their pain-related fear can be a powerful intervention for chronic pain. A decline in pain related fear may reduce pain vigilance, resulting in a decline in reported pain intensity." The proposed individual psychotherapy with biofeedback would not provide in vivo exposure to feared activities that purportedly generate pain. ACOEM chapter 12 does not endorse biofeedback for either acute or chronic pain.

The rationale for the opinions stated in this report are based on clinical experience and standards of care in the area as well as broadly accepted literature which includes numerous textbooks, professional journals, nationally recognized treatment guidelines and peer consensus.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

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This decision by the reviewing physician with Professional Associates is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

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. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk
TDI-Division of Workers' Compensation
P. O. Box 17787
Austin, TX 78744

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.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the patient via facsimile or U.S. Postal Service this day of 11/03/05 from the office of Professional Associates.

Sincerely,

Lisa Christian
Secretary/General Counsel