


INDEPENDENT REVIEW INCORPORATED

Re: MDR #: M2 06 1210 01 **Injured Employee:** ____
DWC #: ____ **DOI:** ____
IRO Cert. #: 5055 **SS#:** ____

TRANSMITTED VIA FAX TO:

TDI, Division of Workers' Compensation

Attention: ____

Medical Dispute Resolution

Fax: (512) 804-4868

RESPONDENT: **Texas Mutual Insurance Co.**

TREATING DOCTOR: **Marsha Miller, DC**

REQUESTOR: **Behavioral Healthcare Associates**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. 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 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. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Ph.D. in psychology and is a practicing, licensed psychotherapist.

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

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.

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 June 2, 2006.

Sincerely,



Jeff Cunningham, DC
Office Manager

**REVIEWER'S REPORT
CASE NUMBER**

Information Provided for Review:

1. Records from the carrier
2. Records from the requestor
3. Records from the treating doctor

Clinical History:

This case concerns a man who had a back injury and subsequent 3-level fusion. He had some participation in a pain management program. He has major depression.

Disputed Services:

Psychotherapy 1 time per week for 8 weeks.

Decision:

The reviewer disagrees with the previous adverse determination

Rationale:

Documentation supports the presence of major depression, which is a common complication in chronic pain. Psychotherapy is an appropriate treatment for this condition and this case.

Screening Criteria/Publications/Research Literature Utilized:

Professional experience in chronic pain, depression, and psychotherapy.