



DATE OF REVIEW: 8/31/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Please determine the medical appropriateness of the previously denied request for 6 sessions of individual counseling.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas licensed Psychiatrist.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The previously denied request for 6 sessions of individual counseling.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/20/07.**
- **Company Request for Independent Review Organization dated 7/20/07.**
- **Notice to CompPartners, Inc. of Case Assignment dated 8/16/07.**
- **Notice of Assignment of Independent Review Organization dated 8/16/07.**
- **Fax Cover Sheet dated 8/20/07, 8/16/07, 7/20/07.**
- **Independent Review Organization Request Form (unspecified date).**
- **Request for a Review by an Independent Review Organization dated 7/20/07.**
- **Determination Notification Letter dated 6/26/07, 6/4/07.**

- **Appeal for Pre-Authorization Reconsideration dated 6/19/07.**
- **Pre-Authorization Certification Request dated 5/29/07.**
- **Note (unspecified date).**
- **Request for Reconsideration of Denial of Therapy dated 7/16/07.**
- **Evaluation Report dated 4/24/07.**
- **Review Determination Notes/ Update Notes /Referral Notes dated 6/26/07, 6/21/07, 6/19/07, 6/1/07, 5/31/07.**
- **Fax Communication Result Report dated 7/20/07.**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: When driving a forklift, he hit a pothole, which caused severe jarring.

Diagnosis: Posttraumatic stress disorder and depression.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The claimant is a old male who, on xx/xx/xx, suffered a work-related back injury while driving a forklift and hit a pothole which caused severe jarring. He has been treated with electrical stimulation ultrasound, chiropractic manipulation and therapeutic exercises, and medications. He had a past psychiatric history of posttraumatic stress disorder and depression for which he was getting Trazodone, Zoloft, and Xanax prescribed through the VA system. According to a behavior health evaluation done by Dr. on April 24, 2007, since the injury, the claimant's depression was worse, and there were added financial stressors. Assuming that by "therapeutic exercises," Dr. means physical therapy according to the Official Disability Guidelines, cognitive behavior therapy for chronic low back pain is recommended "consider separate psychotherapy, cognitive behavior therapy referral after 4 weeks if lack of progress with physical therapy alone. Initial trial of 3 psychotherapy visits over 3 weeks with evidence of objective functional improvement, total of up to 5 to 6 visits over 5 to 6 weeks (individual sessions)." From the note provided at this point, this reviewer could not tell if this is a retrospective review. It says prospective, so the recommendation would be a trial of 3 psychotherapy visits over 3 weeks with evidence of objective functional improvement, a total of up to 5 to 6 visit over 5 to 6 weeks and if it is retrospective, then 6 visits over 6 weeks.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.
- AHCPR – AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES.
- DWC – DIVISION OF WORKERS' COMPENSATION POLICIES OR

GUIDELINES.

- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN.
- INTERQUAL CRITERIA.
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS.
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES.
- MILLIMAN CARE GUIDELINES.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES. 2006/2007. Cognitive Behavior Therapy, Chronic Low Back pain.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHRIOPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).

CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider 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 the decision before the referral to CompPartners, Inc.
