DATE OF REVIEW: 05-06-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Denial of preauthorization approval for Psychotherapy 1 day per week x 6 weeks

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

Certified by the American Board of Psychiatry & Neurology
General Certificate in Psychiatry

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/NDC	Upheld/Overturn
xx/xx/xx			847.2	90806	Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notices of Preauthorization Denial (03-14-07 and 04-04-07)
Letters dated 01-10-07 and 03-19-07
Practitioner evaluation and notes from 01-11-07 through 02-05-07
Physical Therapy notes from 01-10-07 through 02-08-07
Mental Health Evaluation dated 02-28-07
Diagnostic Screening dated 02-28-07

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant was injured on xx/xx/xx while working on machinery at work. The claimant felt a "pop" in her back and experienced pain radiating down the left leg. Despite physical therapy, pain medications, muscle relaxants, and antidepressants, the claimant continues to experience pain and increasingly severe depression.

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

The evaluation of xx/xx/xx reports lumbar sprain/strain, rule out HNP. MRI was reported as showing "Broad Central and left paracentral protrusion of disc material at L4-L5 level. There is potential for displacement of the crossing left L5 nerve root."

On 2/28/2007, the "Clinical impressions" are of severe depression with anhedonia confirmed by clinical history, mental status evaluation, and elevated score on Beck Depression Scale.

It is eminently clear that the claimant now suffers from a clearly defined depressive illness coming on in the context of chronic pain and limitation of movement. Cognitive therapy is a clearly defined behavior centered treatment whose effectiveness has been well documented. The treatment plan purposed specifically targets symptoms relevant to the psychiatric aspects of the claimant's pain and depression. Available clinical data supports a finding of medical necessity for provision of 6 cognitive therapy sessions.

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 JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**