

DATE OF REVIEW: 10/26/07**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Individual counseling 1 x Wk x 4 Wks

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

This case was reviewed by a board certified psychiatrist on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

<i>Primary Dx Code</i>	<i>HCPCS/ NDC</i>	<i>Units</i>	<i>Begin/End Date</i>	<i>Type Review</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Uphold / Overturned</i>
742.2	90806		8/24/07-10/31/07	Prospective				Overturned
722.83	90806		8/8/07-10/31/07	Prospective				Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 10/4/07.
2. Determination Notices – 8/10/07 and 8/31/07.
3. Records and Correspondence from Healthcare – 2/13/07-9/21/07.
4. Records and Correspondence from MRI – not dated.
5. Records and Correspondence from Healthcare – 2/19/07-4/9/07.

PATIENT CLINICAL HISTORY:

This case concerns an adult male who sustained a work related injury. Records indicate that while stepping off a conveyor line, he fell and hurt his lower back. Records also indicate he felt severe pain. Diagnoses have included chronic pain disorder, post laminectomy syndrome, lumbago, and displacement of lumbar vertebra. Evaluation and treatment for this injury has included medication, work hardening program with psychotherapy, x-rays, MRIs, a discogram, surgery, and chiropractic treatment.

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

The MAXIMUS physician reviewer indicated that In a letter dated 8/23/07, Mr. LPC, makes a well-stated case for approval of additional psychological treatment as part of a comprehensive treatment program. The MAXIMUS physician reviewer noted the patient had only has 6 counseling sessions two years ago. The MAXIMUS physician reviewer explained the type of treatment, skill of provider, and motivation are not documented. The MAXIMUS physician reviewer also indicated that other than a notation that the program “helped a little bit”, there is no documentation regarding the patient’s response to treatment. The MAXIMUS physician reviewer noted both Mr., in his letter dated 8/23/07, and Mr., in a letter dated 3/9/07, outlined a rigorous treatment plan designed specifically to treat the patient’s type of disorder. The MAXIMUS physician reviewer indicated the possible benefits in this patient far outweigh the costs of the proposed treatment. The MAXIMUS physician reviewer explained that this request for individual counseling is consistent with Official Disability Guidelines which indicate that multidisciplinary biosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. Therefore, the MAXIMUS physician reviewer determined that the requested individual counseling is medically necessary for treatment of this patient’s condition.

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**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TCADA 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)**