



## CompPartners Final Report



CompPartners Peer Review Network  
Physician Review Recommendation  
Prepared for TDI/DWC

**Claimant Name:** \_\_\_\_\_  
**Texas IRO #:** \_\_\_\_\_  
**MDR #:** M2-06-0775-01  
**Social Security #:** \_\_\_\_\_  
**Treating Provider:** Dennis Gutzman, MD  
**Review:** Chart  
**State:** TX  
**Date Completed:** 3/9/06

### **Review Data:**

- **Notification of IRO Assignment dated 2/14/06, 1 page.**
- **Receipt of Request dated 2/14/06, 1 page.**
- **Medical Dispute Resolution Request/ Response dated 1/27/06, 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Table of disputed Services (date unspecified), 1 page.**
- **Notice of Utilization Review Findings dated 12/20/05, 2 pages.**
- **Notice of Intent to Issue an Adverse Determination dated 11/28/05, 1 page.**
- **Case Review dated 2/22/06, 2/9/06, 4 pages.**
- **Psychiatric Service Report (date unspecified), 2 pages.**
- **Cover Sheet dated 2/20/06, 1 page.**
- **SOAP Note dated 7/21/03, 6/24/03, 4 pages.**
- **Office Visit dated 10/4/04, 5/26/04, 9/22/03, 9/2/03, 8/4/03, 5 pages.**
- **Lumbar Spine Evaluation dated 11/19/03, 1 page.**
- **Office Notes dated 10/4/04, 1 page.**
- **Range of Motion Examination dated 10/4/04, 15 pages.**
- **Texas Workers' Compensation Work Status Report dated 10/4/04, 1 page.**
- **Medication Management Referral dated 6/10/05, 1 page.**
- **Evaluation dated 6/10/05, 5 pages.**
- **Chronic Pain Program dated 8/5/05, 1 page.**
- **Mental and Behavioral Health Consultation and Progress Note dated 8/5/05, 1 page.**
- **Request for an Appeal dated 12/9/05, 3 pages.**

**Reason for Assignment by TDI/DWC:** Determine the appropriateness of the previously denied request for individual counseling and biofeedback, one time a week for four weeks.

**Determination: UPHeld** - previously denied request for individual counseling and biofeedback, one time a week for four weeks.

**Rationale:**

**Patient's age:** 47 years

**Gender:** Female

**Date of Injury:** \_\_\_\_

**Mechanism of Injury:** Injured low back when she picked up some parts from a basket.

**Diagnoses:**

Major depressive disorder, recurrent.

Post laminectomy syndrome.

Spinal stenosis.

Sleep disturbance.

The claimant reported a low back injury on \_\_\_\_, while picking up parts out of a basket at work. She subsequently required an L4-5 and L5-S1 fusion, with L3-4 laminotomy and foraminotomy on an unknown date. On 08/04/03, radiographs indicated apparent solid fusion. The claimant continued to have pain. On 09/04/03, she underwent hardware removal. She treated postoperatively with bracing, a cane and medications. On 11/19/03, radiographs noted the fusion to be intact. She was treated for persistent pain and depression. She apparently attended an interdisciplinary pain program. On 08/05/05, she received authorization for four sessions of individual therapy. A request was made for biofeedback at the same time. The claimant apparently did not complete three sessions. When attempts were made to extend the sessions, the authorization had expired. A repeat request has been made. This reviewer cannot recommend individual counseling and biofeedback, once a week for four weeks, as being medically necessary, at least from an orthopedic surgical standpoint, or from a musculoskeletal standpoint. This reviewer cannot comment on the claimant's psychological disease or her psychological condition. The request for the individual counseling and biofeedback comes from a psychiatric evaluator, and this would fall outside the realm of this reviewer's expertise. From the standpoint of the claimant's musculoskeletal condition and her orthopedic disease, there was no evidence that the biofeedback and individual counseling will lead to any significant further improvement. The claimant is more than five years post initial injury and has undergone extensive treatment.

**Criteria/Guidelines utilized:** TDI/DWC rules and regulations.

Physical Medicine and Rehabilitation, Second Edition, Chapter 42, page 927, by Randall L. Braddom.

**Physician Reviewers Specialty:** Orthopedic Surgeon

**Physician Reviewers Qualifications:** Licensed M.D.

**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.**

### 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.