

RYCO MedReview

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 04/19/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual counseling with biofeedback (90806, 90901)

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

Board Certified in Orthopedic Surgery

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with M.D. dated 01/08/03
An EMG/NCV study interpreted by M.D. dated 08/10/04
Evaluations with DP.A.-C. for D.O. dated 09/01/04, 10/06/04, 11/09/04, 12/07/04, 12/28/04, 03/03/05, 03/31/05, 05/03/05, and 06/28/05

Evaluations with Dr. dated 09/20/04, 05/31/05, 08/17/05, 09/16/05, 10/25/05, 12/29/05, 02/08/06, 03/16/06, 04/13/06, 05/17/06, 06/21/06, 07/06/06, 08/08/06, 08/22/06, 09/21/06, 11/01/06, 11/29/06, 01/24/07, and 03/21/07
A preauthorization request from Dr. (no credentials were listed) dated 09/20/04
A behavioral health consultation with M.A., L.P.C. dated 09/20/04
Procedure notes from M.D. dated 09/23/04 and 09/21/05
A letter of approval from Ph.D. dated 09/24/04
Individual psychotherapy with Mr. dated 10/11/04
A letter of approval from M.D. at dated 10/15/04
A procedure note from M.D. dated 12/10/04
Requests for preauthorization from Dr. dated 05/05/05, 09/27/06, 10/12/06, 02/13/07, and 02/28/07
A physical therapy evaluation with Dr. dated 05/11/05
Evaluations with Dr. dated 12/30/05, 01/26/06, 05/11/06, 11/08/06, 12/06/06, 01/05/07, 02/05/07, and 03/07/07
Letters of approval from Ph.D. dated 01/27/06 and 10/02/06
A Functional Capacity Evaluation (FCE) with M.Ed., O.T.R. dated 03/03/06
Letters of approval from M.D. at dated 03/22/06 and 06/07/06
Procedure notes with M.D. dated 04/06/06, 06/29/06, 08/03/06, and 10/26/06
A request for reconsideration letter from dated 05/22/06
A letter of referral from Dr. dated 09/21/06
Behavioral medical evaluations with L.P.C. dated 10/09/06 and 10/12/06
Letters of adverse determination from Dr. dated 10/18/06 and 02/16/07
Laboratory studies interpreted by M.D. dated 01/05/07
A letter of non-authorization from R.N., at dated 02/16/07
An evaluation with D.O. dated 02/19/07
An addendum report from Dr. dated 02/26/07
A letter of non-certification from R.N. at dated 03/05/07
An MRI of the lumbar spine interpreted by M.D. dated 03/05/07
A letter of adverse determination from M.D. at dated 03/06/07
An evaluation with M.D. dated 03/23/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 01/08/03, Dr. recommended a cane, anti-inflammatories, cushioned shoes, and possible hip replacement surgery. An EMG/NCV study interpreted by Dr. on 08/10/04 revealed bilateral chronic L5-S1 radiculopathy with an acute component on the left. An ESI was performed by Dr. on 09/23/04. Individual psychotherapy was performed with Mr. on 10/11/04. On 11/09/04 and 12/28/04, Mr. recommended further ESIs. On 12/10/04, Dr. performed an ESI. A selective root injection was performed by Dr. on 09/21/05. Bilateral SI joint injections were performed by Dr. on 01/26/06 and 05/11/06. On 02/08/06, Dr. recommended a lumbar rhizotomy. Dr. performed a selective neurotomy on 04/06/06. On 04/13/06, Dr. recommended individual counseling and biofeedback, bilateral SI joint injections, and possible dorsal column stimulation. Bilateral SI joint injections were performed by Dr. on 06/29/06. On 08/03/06, Dr. performed a

rhizotomy. On 08/08/06, Dr. continued to request counseling. On 10/09/06 and 12/18/06, Ms. also requested individual psychotherapy and biofeedback. On 10/26/06, Dr. performed a right SI joint injection. On 02/13/07, Dr. requested individual counseling and biofeedback. On 02/16/07, Dr. wrote a letter of adverse determination for the counseling and biofeedback. On 02/28/07, Dr. requested a chronic pain management program. On 03/05/07, Dr. wrote a letter of non-authorization for the pain program. An MRI of the lumbar spine interpreted by Dr. on 03/05/07 revealed marked degenerative changes at L4-L5 and a slight disc protrusion at L5-S1. On 03/06/07, Dr. also wrote a letter of adverse determination for individual counseling and biofeedback. On 03/23/07, Dr. agreed with a hip replacement surgery.

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

This patient has a chronic pain syndrome. Any therapy that favors his focusing on his pain, such as individual counseling, would not be beneficial. This patient has had a surfeit of treatment and has continued to be in chronic pain. The patient proposes anxiety and depression preexisted the injury. At the current time, there is no evidence that he would benefit from the proposed pain management program, the individual counseling, or the biofeedback. The patient would require a Functional Capacity Evaluation (FCE). In reasonable medical probability, the requested services in this context would lead to reinforcement of the patient's chronic pain syndrome. According to both the ACOEM Guidelines and the ODG, the patient would not be a candidate for such services.

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 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)**