CompPartners

Notice of Independent Review Decision

DATE OF REVIEW: **8/9/07** **AMENDED DATE ; 8/17/07**

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of the previously denied request for six individual psychotherapy sessions.

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

Texas Licensed Physical Medicine and Rehabilitation D.O.

REVIEW OUTCOME

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

X Upheld (Agree)

□ Overturned (Disagree)

□ Partially Overturned (Agree in part/Disagree in part)

The previously denied request for six individual psychotherapy sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Request Letter dated 7/31/07.**
- **Fax Cover Sheet dated 7/31/07, 7/26/07, 7/24/07, 7/19/07, 7/10/07, 6/28/07, 6/13/07.**
- **Notice to CompPartners, INC. of Case Assignment dated 7/26/07.**
- **Notice of Assignment of Independent Review Organization dated 7/26/07.**

- **Follow-up dated 7/25/07, 6/27/07, 6/6/07, 5/30/07.**
- **E-Mail dated 7/24/077/19/07.**
- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/19/07.**
- **Request Form dated 7/10/07.**
- **Review Determination dated 7/3/07, 6/18/07.**
- **Authorization Request dated 6/28/07, 6/13/07.**
- **Request for Behavioral Health Treatment dated 6/25/07.**
- **Initial Behavioral Medicine Consultation dated 6/1/07.**
- **History and Physical dated 5/16/07.**
- **Prescription dated 5/16/07.**
- **Patient Information Sheet dated (unspecified).**

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx years
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Lifting bags of cement weighing more than 100 pounds.

Diagnosis: Cervical displaced disc, lumbar displaced disc, bilateral cervical radiculopathy, bilateral lumbar radiculopathy, and intractable pain.

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

This male sustained an industrial lower back injury on xx/xx/xx when he was lifting bags of cement weighing more than 100 pounds. He picked up one bag of cement and twisted his torso sustaining immediate pain and numbness of the neck and low back with numbness of bilateral upper and lower extremities. He was referred to the Treatment Center in, Texas for definitive treatment and came under the care of , D.O. Dr. diagnosed the following conditions: Cervical displaced disc, lumbar displaced disc, bilateral cervical radiculopathy, bilateral lumbar radiculopathy, and intractable pain. The physical examination performed by Dr. on xx /xx/ xx demonstrated no focal neurologic impairment. However, there were several subjective findings of numbness, tingling, and dysesthesia of bilateral upper and lower extremities, decreased deep tendon reflexes and bilateral lower extremities, and decreased range of motion of the cervical and lumbar spine with regard to flexion, extension, and rotation. Dr. recommended physical therapy, no work for 30 days and cervical/lumbar MRI scans, and he prescribed Vicodin ES one q.i.d. for pain and Flexeril 10 mg one t.i.d. for muscle spasm. He requested cervical and lumbar MRI scans and a physician follow-up visit of 3-4 weeks. The claimant returned to Dr. on 5/30/07. Reportedly, he was unimproved. Because of claustrophobia, he was unable to obtain the MRI scans, and therefore, Dr. prescribed Valium prior to the MRI scans and he ordered open MRI scans of the cervical and lumbar spine. He requested continuation of physical therapy, and he also requested electrodiagnostic studies of bilateral upper and lower extremities. The claimant returned to Dr. on 6/6/07. He remained unchanged with regard to his complaints and the physical examination. Dr.

reviewed the cervical and lumbar MRI scans. Dr. was of the opinion that these particular scans demonstrated neurocompression and was recommending surgical decompression procedures. He referred the claimant to Dr. who ordered further diagnostic testing including upper and lower extremity electrodiagnostic studies. The claimant returned to Dr. on 6/27/07 with continuing musculoskeletal complaints and examination findings being unchanged. The diagnosis also remained unchanged. Dr. recommended neurosurgical evaluation, physical therapy treatment, and no work for 30 days. He prescribed additional Vicodin ES tablets one q.i.d. for pain and Flexeril as needed. He was to continue Restoril for the sleep disturbance and return in one month for physician follow-up. According to the submitted medical records documentation, most recently, the claimant was seen by Dr. on 7/25/07. The claimant remains unchanged with regard to both his complaints and the objective physical examination findings. The impressions remained changed with the addition of an associate sleep disturbance. Dr. prescribed Dalmane 30 mg one capsule at bedtime and he continued the Vicodin ES tablets one q.i.d. He was requesting continuation of physical therapy and no work for 30 days. He also recommended neurosurgical consultation as soon as possible and a follow-up visit at one month. The claimant was also to continue his muscle relaxant medication. Reportedly, Dr. also ordered psychotherapy sessions for the claimant. However, this was not specifically documented in the available progress notes submitted for review. This request was non-authorized on two occasions – initial determination that was dated 6/18/07 and the subsequent appeal dated 7/3/07, which also upheld the non-authorization of the six individual psychotherapy sessions. This is now at an independent review organization level. The behavioral health for psychological evaluation determined that the claimant demonstrated severe symptomatology on the Beck Depression Inventory and the Beck Anxiety Inventory. The claimant also sustained significant change in self-perception since the work injury of xx/xx/xx including anger or disappointment with himself. He was also complaining of an associated sleep disturbance as he was awaking once per hour. Prior to the work injury, he was sleeping six hours of restorative sleep, and after the work injury of xx/xx/xx, he reported sleeping only two fragmented hours at night. Additionally, there was a loss of appetite resulting in a 10-pound non-volitional weight loss and reduced energy since the work injury. The specific treatment goals with regard to the behavioral health management include improvement of the claimant mood as he is overwhelmed by stressors that attacks his coping and problem solving skills support, resumption of premorbid enjoyable activities reduce his mood symptoms with instruction regarding self regulation of stress and diaphragmatic breathing with progressive muscle relaxation identify challenge or replace cognitive distortions improve occupational and physical functioning which may influence his mental health status, vocational plans and goals will be addressed. The requested behavioral health individual psychotherapy sessions weekly for six weeks is necessary to reduce the claimant pain experience and advance the claimant to return to work as well as obtain medical case closure. This was according to the request for reconsideration dated 6/25/07. In summary, the requested six individual psychotherapy sessions on weekly basis is non-certified for several reasons: There is no clear documented depressive symptomatology in the physician progress notes by Dr. with the exception of an associated sleep disturbance which may be pain related rather than with regard to the mental health aspect. Additionally, Dr. did not prescribe any psychoactive medication, and furthermore, there was no direct physician documentation indicating that Dr. did refer the claimant for the psychotherapy evaluation and treatment program. Therefore, this request remains non-authorized.

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.

□ 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.