



IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

DATE OF REVIEW: 12/17/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy one time a week for four weeks

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

Texas License
Clinical Psychologist
Member American Academy of Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Designated Doctor Evaluation, dated 06/20/07
2. Functional Capacity Evaluation dated 08/13/07.
3. Independent Medical Evaluation, M.D., dated 08/22/07.
4. Initial psychological evaluation, Healthcare dated 08/28/07.
5. Insurance denial letters dated 10/12/07 & 11/07/07.
6. Letter of appeal, Healthcare dated 10/30/07.
7. ***Official Disability Guidelines.***

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee was initially injured at work and then reinjured while employed as a crane operator. While lifting a 60 pound pad over his head, the employee experienced pain in his right shoulder. The employee received physical therapy and was returned to work around February, 2007.

On the employee's reinjury, he was picking up large wood planes onto a deck and experienced the same pain.

Deleted: 10/8/2007

Records were somewhat unclear, but it was suggested that the employee then received additional physical therapy and was treated conservatively with medications to include Tramadol and Tylenol.

On 06/20/07, the designated doctor did not believe the employee had reached Maximum Medical Improvement (MMI). The diagnoses were shoulder sprain/strain, supraspinatus tendonitis, and subacromial and subdeltoid bursitis. The designated doctor recommended injection of steroid to the bursa and around the supraspinatus tendon. If the employee did not improve with therapy and injections, the recommendation was repeat MRI to rule out surgical lesion. If surgery was not indicated, then a work hardening program was recommended.

There was a Functional Capacity Evaluation (FCE) performed on 08/13/07. It was noted that the employee was very cooperative during the evaluation and gave a genuine effort. The employee exhibited some fear of reinjury during the FCE, The recommendation on that date was referral for a full psychological evaluation, as well as ten sessions of work hardening/conditioning followed with a second FCE.

On 08/22/07, the employee presented to M.D., for an Independent Medical Evaluation (IME). The diagnoses only included right shoulder sprain/strain which had resolved. The remainder of the employee's pain was described as due to a preexisting degenerative disease condition. It was Dr. opinion that the employee had reached Maximum Medical Improvement (MMI) in regard to the right shoulder with a 0% impairment rating.

On 08/28/07, there was an initial psychological evaluation performed at Healthcare. The assessment on that date indicated that the employee would be able to psychologically enter the rigors of the work hardening program. The employee was noted to have no anxiety (BAI=0) and BDI of 5 was within normal limits. There was nothing abnormal noted on the mental status examination, and sleep was also reported to be good. He was to be monitored during his weekly group psychotherapy sessions, and if his emotional status changed during the course of the program, he was to be considered for a psychological reevaluation and alternative treatment recommendations. The assessment results indicated the employee would be able to participate in group therapy as part of the return to work program.

On 10/12/07, there was a denial from Insurance for individual counseling sessions.

On 10/24/07, there was a request for an appeal for the individual counseling sessions from Healthcare.

It is unclear whether or not work hardening was approved, but individual psychotherapy one time a week for four weeks was then requested, with an addendum to the report that gave treatment goals. These included stabilization of depressed mood, stabilization of anxious mood, independent utilization of pain and stress management skills, compliance with the medical plan, and reduced identification with the sick role, as evidenced by improved sleeping patterns. The employee was given no psychological diagnoses.

Deleted: 10/8/2007

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

The goals for treatment discussed above are illogical and cannot be considered medically necessary since the employee evaluation showed no evidence of psychopathology, no decreased mental status, and no sleep problems or evidence of non-compliance with doctor’s medication regimen or other directives.

In addition, the ODG TWC stress chapter states that initial evaluations should “focus on identifying possible red flags or warning signs for potentially serious psychopathology that would require immediate specialty referral. Red flags may include impairment of mental functions, overwhelming symptoms, signs of substance abuse, or debilitating depression. In the absence of red flags, the occupational or primary care physician can handle most common stress-related conditions safely”. The determination that medical necessity could not be established at this time is upheld. (See *the following from ODG Work Loss Data, 2007*):

Psychological evaluations: Recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the employee in their social environment, thus allowing for more effective rehabilitation. ([Main-BMJ, 2002](#)) ([Colorado, 2002](#)) ([Gatchel, 1995](#)) ([Gatchel, 1999](#)) ([Gatchel, 2004](#)) ([Gatchel, 2005](#))

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

1. ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Deleted: 10/8/2007