

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 15, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Four (4) Individual Psychological Counseling Sessions

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

Board-certified Internal Medicine.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/10/07, 11/6/07

ODG Guidelines and Treatment Guidelines

Injury Report, 2/17/94

MD, 4/15/94, 5/11/94, 5/16/94, 6/15/94, 7/21/94, 9/26/94, 11/21/94, 1/17/95, 3/2/95, 4/10/95, 5/11/95, 6/21/95, 8/16/95, 11/8/95, 1/10/96, 2/21/96, 3/27/96, 5/8/96, 6/7/96, 6/19/96, 10/28/96, 1/8/97, 3/3/97, 3/25/97, 5/21/97, 9/2/97, 10/21/97, 12/17/97, 2/18/98, 3/23/98, 4/15/98, 6/10/98, 10/12/98, 12/7/98, 2/1/99, 3/29/99, 5/24/99, 7/26/99, 10/24/99, 1/7/00, 3/20/00, 6/5/00, 8/30/00, 11/1/00,

1/31/01, 7/30/01, 4/28/02, 7/22/02, 12/2/02, 4/7/03, 8/1/03, 12/8/03, 5/24/04,
9/22/04, 10/11/04, 3/28/05, 9/6/05, 6/16/06, 10/16/06, 2/12/07
Operative Reports, , 6/7/94, 7/30/96, 8/21/97
MD, 1/25/96, 2/6/96, 3/7/96, 5/7/96
MD, FACS, 3/7/96, 5/2/96
MD, FACS, 4/4/94
MR Lumbar Spine, 3/17/94
LVN, 8/10/96, 8/11/96

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant injured his lower back in xx/xx. MRI showed L4-5 disc herniation. He underwent L4-5 laminectomy and fusion in June 1994. He then underwent L4-S1 laminectomy and fusion in July 1996. The last physician evaluation is ten months ago. Treatment at that time consisted of medications. This treatment has been unchanged for several years. The claimant is working full time.

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

I have reviewed the applicable guidelines and the peer-reviewed medical literature concerning psychological counseling in the treatment of chronic low back pain. The claimant in this case is working full time and is quite functional. He has been treated with medications for an extended period of time, with neither improvement nor deterioration in his overall condition. It is beyond a degree of medical probability that psychological counseling 13 ½ years post-injury would provide significant benefit. Therefore, the proposed treatment is not medically necessary.

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)