

RYCO MedReview

DATE OF REVIEW: 05/16/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy once a week for eight weeks with hypnotherapy once a week for eight weeks (90806, 90880)

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

Licensed

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 operative report from, M.D. dated xx/xx/xx
Evaluations with Dr. dated 02/06/07 and 02/16/07
Evaluations with, M.D. dated 02/09/07, 02/12/07, 02/16/07, 02/26/07, 03/05/07, 03/19/07, 04/02/07, and 04/12/07
An evaluation with, D.C. dated 02/09/07
A behavioral evaluation with, M.A., L.P.C. dated 02/09/07

Letters of adverse determination from, Ph.D. at dated 02/15/07, 02/20/07, and 03/06/07

A letter from dated 03/08/07

A letter of non-certification from, R.N. at dated 03/06/07

An evaluation with, M.D. dated 04/05/07

A request for an IRO from Ms. dated 04/18/07

An undated report regarding back pain

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, Dr. performed cervical spine surgery. On 02/06/07, Dr. requested postoperative rehabilitation and prescribed Darvocet. On 02/09/07, Ms. requested individual psychotherapy and hypnotherapy. On 02/15/07, 02/20/07, and 03/06/07, Dr. wrote letters of adverse determination for individual and hypnotherapy. On 02/16/07, Dr. requested further surgery. On 04/05/07, Dr. also requested surgery. On 04/18/07, Ms. again requested individual psychotherapy and hypnotherapy.

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

Based on the records and the medical and psychological evidence provided, eight individual sessions of individual psychotherapy and eight sessions of hypnotherapy are not reasonable and necessary. However, the ODG Guidelines do recommend a course of psychotherapy for both pain (three session trial) and depression (six session trial). Given that the documentation demonstrates both symptoms of depression and ongoing chronic pain with an extended recovery period, a trial of six individual treatment sessions is supported. The ODG specifically cites low back problems but under cervical injuries, the low back section is referenced concerning the criteria for providing psychological treatment. Therefore, it was established that individual psychotherapy (90806) once a week for six weeks is reasonable and necessary as related to the original injury.

There is no reference in the ODG concerning the medical necessity of hypnotherapy in the treatment of chronic pain or depression. No references were provided by the provider. Therefore, there is no medical necessity established for the use of hypnotherapy in the treatment of this patient. The request for eight weeks of hypnotherapy (90880) once a week for eight weeks was not reasonable and necessary as related to the original injury.

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)