

IRO REVIEWER REPORT

DATE OF REVIEW: 10/23/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy and biofeedback 2 x for 6 weeks

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

The TMF physician reviewer is a licensed chiropractor who is on the TDI-WC Approved doctor's list and is familiar with the treatment or proposed treatment.

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.

It is determined that the individual psychotherapy and biofeedback 2 x wk for 6 weeks is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Information for requesting review by an IRO – 10/09/07

Letter of determination– 09/13/07, 12/03/07

Reconsideration for preauthorization request for behavioral health treatment – 09/26/07

Physician Patient Face Sheet 09/10/07
Request for psychological evaluation – 08/15/07
Behavioral Medicine Re-evaluation – 09/06/07
Office visit notes from Dr.– 01/31/07 to 08/25/07
Behavioral health individual psychotherapy aftercare pre-authorization request – 08/09/06
Chiropractic Center Patient Face Sheet – 01/06/06
Interdisciplinary Pain Rehabilitation Discharge Summary – 07/28/06
Pain Management Evaluation Report – 06/29/04
Continuation: Chronic pain management program preauthorization request – 05/26/06
Physician request for psychological evaluation & testing, chronic pain management and Individual counseling, and FCE – 01/05/06
Treatment notes from Injury 1 Center – 05/26/06
Center list of Interdisciplinary Pain Treatment Components – No date
Center Chronic Pain Management Program Design – No date
Chronic pain management day treatment design – No date
Letter from Injury 1 Treatment Center to Dr.– 05/25/06
Report of functional capacity evaluation – 05/25/06
Behavioral Health Treatment Preauthorization Request – 09/10/07
Center report of Environmental Intervention – 10/03/07
Note: The URA/carrier did provide ODG guidelines for psychotherapy

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury to his right wrist and low back when he was pulling a roll of carpet from overhead. The roll slipped, causing him to fall backwards. The patient has been treated with medication, physical therapy, 6 weeks of work Hardening, epidural injections, individual psychological therapy and 25 sessions of Chronic pain management.

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

This patient has had a large amount of psychological treatment since his on the job Injury. He has had individual psychotherapy, 6 weeks of work hardening psychotherapy (included in this program) and chronic pain management (psychotherapy is included in this program). Even with this amount of therapy, the Records indicate that he has not been independently engaging in the techniques Learned during individual psychotherapy (i.e. hypnosis, progressing relaxation and CBT strategies). The medical record documentation does not confirm the success of the previous psychological treatment. Given the failure of the previous treatment, it is very unlikely that any additional similar treatment would produce favorable results. ODG's allow for this type of treatment for this type of injury but not of the magnitude and frequency that this patient has received.

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)