

RYCO MedReview

DATE OF REVIEW: 10/29/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Four sessions of individual psychotherapy

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

Board Certified in Psychiatry
Board Certified in Neurology in Psychiatry
Board Certified in Addiction
Board Certified in Forensic Psychiatry
Board Certified in Pain 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)

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.

Four sessions of individual psychotherapy - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A diagnostic interview and treatment plan from, dated xx/xx/xx
Undated treatment goals from,
A Physical Performance Evaluation (PPE) with Dr., dated xx/xx/xx
A request from, L.P.C. dated 08/02/07
A letter of non-certification, according to the ODG, from, M.D. dated 08/08/07
An undated request for appeal letter from Ms.
A letter of non-certification, according to the ODG, from, M.D. dated 09/05/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, Mr. recommended a minimum of 10 days in an interdisciplinary chronic pain management program. A PPE with Dr. on xx/xx/xx revealed the patient functioned at the light physical demand level, but her job required the medium physical demand level. On 08/02/07, Ms. wrote a request for four sessions of individual counseling. On 08/08/07, Dr. wrote a letter of non-certification for the individual counseling. On an unknown date, Ms. requested an appeal for the individual psychotherapy. Dr. wrote a letter of non-certification for four sessions of individual therapy on 09/05/07.

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

In my opinion, the four requested sessions of individual psychotherapy are reasonable and necessary as related to the original injury. The records reviewed indicate the employee was injured on xx/xx/xx. She has had failed back syndrome and in the past has attended a chronic pain program and has undergone individual psychotherapy. The report dated xx/xx/xx by, documents that the patient is on Vicodin and Mobic. She has limited education. The Beck Depression Inventory II is consistent with depressive symptoms. The Beck Anxiety Inventory is consistent with significant anxiety symptoms and she was provided the diagnosis of DSM-IV of 307.89, 296.33, and 300.02 as a direct result of the xx/xx/xx injury. It is noted that she is profoundly depressed, scoring 33 out of 63 points on the BDI and moderately anxious, scoring 17 out 63 points on the BAI. She has a chronic pain syndrome that has persisted. The previous reviewer denied the requested treatment in part on the basis that the requested treatment was for chronic low back pain. However, the requested treatment is, to this reviewer, for the treatment of her psychiatric diagnosis secondary to the work injury. The ODG web based guidelines for therapy for depression and anxiety under cognitive therapy for depression do indicate an initial trial of six visits over six weeks and with evidence of objective functional improvement then a total of up to 13 visits over a 13 to 20 weeks of individual sessions. Specifically, there is no evidence in the web based guidelines to indicate that if persons have had prior treatment and that has failed, then further individual therapy is contraindicated or not recommended. Quite the contrary. The symptoms of depression and anxiety related to chronic pain syndrome tend to be persistent and wax and wane over time. Therefore, the request for the four sessions of individual psychotherapy are clinically consistent with the history as identified and are consistent with web based ODG Guidelines for cognitive therapy.

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)**