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Notice of Independent Review Decision

DATE OF REVIEW: 04/07/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Item in dispute: Individual psychotherapy one time a week for six weeks

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

Texas Licensed Psychologist

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. Employers First Report of Injury or Illness dated xx/xx/xx.
2. CT scan of the abdomen and pelvis dated 02/14/05.
3. MRI of the lumbar spine dated 02/18/05.
4. MRI of the right hip dated 02/18/05.
5. New patient consultation with Dr. dated 03/21/05.
6. Lumbar spine x-rays dated 03/21/05.
7. Daily physical therapy notes dated 03/22/05 thru 04/05/05.
8. Follow up with Dr. dated 04/05/05.
9. Evaluation with Dr. dated 04/11/05.
10. Procedure Note (ESI) dated 04/14/05.
11. Follow up with Dr. dated 05/24/05.
12. New patient evaluation with Dr. dated 08/12/05.
13. Follow ups with Dr. 08/18/05, 08/23/05, 09/01/05, 09/07/05, 09/19/05, 09/28/05, 10/06/05, 10/12/05, 11/01/05, 11/10/05, 11/18/05, 11/28/05,

12/06/05, 12/27/05, 01/06/06, 01/20/06, 02/03/06, 03/02/06, 03/22/06,
05/16/06, 06/09/06, 08/09/06, 08/29/06, 09/19/06, 03/27/07, 04/16/07,
06/14/07, 01/07/08.

14. Work Status report 08/19/05, 09/20/05, 11/11/05, 12/07/05, 01/09/06,
02/06/06, 03/03/06, 05/17/06.

15. Initial behavioral consultation 08/26/05

16. Electrodiagnostic and nerve conduction studies 09/01/05

17. Individual psychotherapy notes dated 09/27/05 thru 02/17/06.

18. New patient evaluation with Dr. 10/05/05.

19. Procedure note (ESI) 10/11/05.

20. Reevaluation including range of motion testing with Dr. 10/19/05.

21. Evaluation with Dr. 12/19/05.

22. Psych reassessment 01/10/06.

23. Lumbar myelogram 01/24/06.

24. Follow up with Dr. 01/30/06, 04/26/06.

25. Evaluation with Dr. 02/27/06.

26. Investigation and surveillance report 05/11/06.

27. Functional capacity evaluation 05/24/06.

28. Required Medical Evaluation 06/21/06.

29. Follow up with Dr. 08/22/06, 09/12/06.

30. CPMP and Group therapy progress notes dated 09/11/06 thru 09/12/06.

31. Designated Doctor Evaluation 03/13/07.

32. Required medical examination 08/30/07.

33. Initial Behavioral medicine consultation 01/22/08.

34. Request for individual psychotherapy 02/06/08.

35. Initial denial by Dr. 02/08/08.

36. Reconsideration request 02/11/08.

37. Second denial by Dr. 02/18/08.

38. ***Official Disability Guidelines.***

PATIENT CLINICAL HISTORY [SUMMARY]:

The employee is a xx year old female who reported an onset of low back pain on xx/xx/xx while going up and down a ladder moving boxes while working at xxxx. After reporting the injury, the employee reported she had also had a previous injury in xx/xx but was advised to not report the injury. Initial treatment consisted of rest, medications, some physical therapy, and one chiropractic session that reportedly exacerbated her pain. She also underwent x-rays and MRI. The MRI was indicative of multilevel bulging. The employee was also noted to have received some epidural injections which provided relief per the notes.

In August, 2005, the employee was evaluated for psychological status due to lack of overall improvement. At that time, she was not working and was on ibuprofen only. She reported significant pain, pain interference with activities and other lifestyle changes to include disrupted sleep, emotional distress, and suicidal ideations. She also reported loss of control and lack of confidence, low mood, sadness, fatigue, guilt, worry, and difficulty concentrating. Beck

depression and anxiety inventories were completed; scores were 29 and 28 respectively. The diagnostic impression was major depressive disorder, severe without psychotic features. Recommendation was made for the employee to begin low level psychotherapy. She was also placed on Elavil. Overall response to individual psychotherapy was good with the majority of goals being met to include elimination of suicidal ideations.

The employee was then referred to Dr. for a pain management evaluation. He noted the employee should continue treatment with Dr. and follow up. The employee continued to receive medications and underwent additional injections reporting improvement. However, while in individual psychotherapy, she was reporting excruciating pain and remained depressed and anxious.

On 12/19/05, the employee was referred to Dr. for a surgical consultation. She presented very anxious, emotional and worried. She also reported she had received injections initially with minimal relief but the second injections were no relief at all. Dr. opined after a thorough examination of the employee, her records and imaging, that she should be sent for another injection and would possibly be an appropriate candidate for decompression. Surgery was reportedly denied.

When seen for follow up individual psychotherapy in December, 2005, the employee reported reduced depression and anxiety but per the notes it was indicated she still had suicidal ideations which is conflicting to prior progress notes that these had subsided.

A psychological reassessment was completed on 01/10/06. At that time, pain was constant, depression and anxiety were severe, suicidal ideations were present, and sleep was improved with medications. Beck scores had reduced to 27 and 18. She was recommended to continue individual psychotherapy and for placement on psychotropic medications.

In February, 2006, the employee was seen for evaluation with Dr.. He refilled medications to include Ultram and Elavil. He also advised continued medical management to include further injections and to possibly pursue recommendation of Dr. to have surgery. However, surgery was denied and upheld on IRO.

In April, 2006, a request for surveillance was made. PI Solutions conducted surveillance on the employee over a three day period from 04/25/06 to 04/27/06. There was some degree of difficulty verifying her presence at the house but when observed she was only mildly active.

When seen for follow up with her treating physician, the employee indicated she no longer wanted to pursue surgical intervention as she felt the insurance company was being mean to her. She was referred for pain management.

On 06/21/06, the employee was seen for a Required Medical Evaluation (RME). The assessment was a lumbar strain that aggravated an underlying degenerated spine. The reviewer opined based on available information the employee should have been able to remain at work at a sedentary physical demand level with occasional lifting with use of a brace. It was also advised continued chiropractic care was excessive and medications changes were needed. It was also noted despite her reports of performing a home exercise program, 99% of the time that she was really only walking and this constituted her home exercise. Surgery was noted to be not needed. The findings also concluded that the employee made no report of depression on the initial questionnaire, and as such it was determined that depression was not related to her injury.

On 08/22/06, the employee was seen for evaluation with Dr.. He made medications changes from Elavil to Effexor and advised a chronic pain management program may be appropriate. There are limited notes regarding the pain program, but it does appear she participated in some sessions.

When seen for follow up with Dr., the employee reported feeling aggravated due to having to participate in the program.

There was then a gap in treatment until the employee was seen for a Designated Doctor Evaluation on 03/13/07. Dr. determined statutory Maximum Medical Improvement (MMI) was as of 02/11/07 and impairment was 5% whole person.

Subsequent to the evaluation, the employee was seen by Dr., and he agreed with the impairment rating. However, the employee considered disputing.

On 08/30/07, the employee underwent a second RME. The employee reported residual low back pain. Reported medications included Darvocet and Excedrin PM. Also eluded was a prior history before the injury of depression for which she received Zoloft. She made no report of depression or treatment for her injury. Upon examination, the reviewer also indicated the employee exhibited no signs of depression or anxiety. He also opined that her diagnosis, major depressive disorder when she was first evaluated psychologically, was evidence of a preexisting condition and not related to her injury. Her condition was noted as stable and not likely to improve with active medical treatment or surgery. Maintenance care only was recommended.

In a subsequent follow up with Dr. , it was noted that the employee's psychological issues and depression had been accepted as compensable. However, there were no notes to support this. Dr. indicated given this was her only remaining problem, she was being referred back to the pain management clinic.

On 01/22/08, the employee was seen for a behavioral medicine consultation. At that time she was on over-the-counter medications only. She reported numerous stressors, functional limitations, and negative changes in her personal

relationships. Her complaints included difficulty sleeping, weight gain, financial strain, difficulty with activities of daily living, frustration and anger, sadness, depression, forgetfulness and poor concentration. Beck depression and anxiety inventories were again completed; scores were 39 and 23 respectively. The diagnostic impression was pain disorder with psychological factors. Recommendation was made for participation in individual psychotherapy.

An initial review and denial was completed on 02/08/08 by Dr.. She indicated the employee had not received treatment since 2006, was only on over-the-counter medications, and had made no attempt to return to work. A letter of reconsideration and response was submitted. It was confirmed that she had not received individual psychotherapy since 2006, but that the employee was in need of individual psychotherapy to resolve her active mood disorder and to address her return to work barriers.

The denial was upheld on appeal on 02/18/08 by Dr.. She denied given lapse in treatment and also concluded that given the employee in addition to individual psychotherapy had also completed some tertiary pain management sessions that there was no rationale for additional therapy.

As a result of these denials, a request for IRO has been filed.

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

I would agree with the denials. The employee had sufficient individual psychotherapy as well as some pain management. Her complaints were inconsistent, and it was determined that her depression was not related to her injury. There is suggestion that the diagnosis was later accepted, however, there was no information provided to support or refute this. The initial denial was appropriate as was the appeal. Additional individual psychotherapy is not medically necessary for this employee.

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

1. ***Official Disability Guidelines***, Return To Work Guidelines (2007 *Official Disability Guidelines*, 12th edition) Integrated with Treatment Guidelines (*ODG Treatment in Workers' Comp*, 5th edition) Accessed Online