

Clear Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 31, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Four (4) Sessions of Individual Counseling

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

MD, Board Certified in Occupational 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, 2/13/08, 2/27/08

IRO Summary Letter from Carrier

Dr. DC, 3/10/06, 3/31/06, 5/11/06, 6/14/06, 7/28/06, 8/3/06, 9/1/06, 10/9/06, 11/3/06, 12/13/06, 1/3/07, 2/6/07, 3/6/07, 3/7/07, 4/4/07, 5/9/07, 6/6/07, 8/3/07, 8/15/07, 10/16/07

Dr., 3/16/06, 4/20/06, 5/4/06, 6/8/06, 6/20/06, 2/22/06

Dr. MD Upper Extremity Eval 5/25/06, 8/24/06, 10/5/06, 11/2/06, 11/30/06, 1/11/07, 3/22/07, 7/23/07

Dr., MD 9/11/06

Dr., MD 9/27/06

Dr. LCSW 9/17/07
Dr. LPC 11/2/07
PPE, DC 11/2/07
Dr.,DC 1/15/08
Dr., DC 1/15/08
MRI Shoulder 4/6/06
MRI Cervical 1/10/07
MRI Elbow 1/10/07
Exam Elbow 3/13/06
Exam Cervical 3/13/06
Exam Thoracic Spine 3/13/06
Exam Lower Spine 3/13/06
Exam Shoulder 3/13/06, 10/22/07
EMG/NCV 6/25/07
Range of Motion Muscle Test 5/17/06
Chest Exam 9/11/06
Cardiolite Study 9/21/06
Exam, 8/10/07
Surgical Notes 4/20/06, 6/20/06, 9/27/06, 2/22/07
Pain Management, 7/27/07
Health Evaluation, 9/17/07
Case History Record, 10/11/07
Doctor's Exam, 11/21/07
Healthcare, 1/3/08, 1/23/08
Initial Evaluation 6/22/06, 10/13/06
Re Evaluation 2/27/07
Evaluation 7/10/07
Daily Treatment Logs 2006 3/10, 3/31, 4/7, 4/13, 4/18, 4/20, 4/26, 4/27, 5/4, 5/5, 5/10, 10/6, 11/2, 11/3, 11/14, 11/28
Daily Treatment Logs 2007 1/26, 2/15, 3/21, 3/23, 3/26, 3/28
Mass. Guidelines
National Clearinghouse Guidelines
ODG Guidelines
ACOEM Guidelines
Clinical Practice Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old with a history of right shoulder injury while working on xx/xx/xx. She subsequently underwent shoulder surgery 9/27/2006. She was placed at MMI on 1/15/2008.

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

The reviewer has read the records provided, including the adverse determination letters, multiple functional capacity evaluations, and the patient's initial psychology evaluation. There was a lack of current clinical evaluation of patient's status with activities of daily living in the records provided.

The patient is a xx year old with a history of right shoulder injury while working on xx/xx/xx. She underwent shoulder surgery 9/27/2006. She was placed at MMI on 1/15/2008.

The reviewer finds that there is a lack of documentation of post-surgery modalities for her pain management and orthopedic evaluation. The Official Disability Guidelines do not support utilization of individual psychotherapy sessions unless there has been documentation of failure of surgical repair and failure to observe improvement on medical program. Therefore, the reviewer finds that four (4) sessions of individual psychotherapy are 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)