

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 23, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed individual psychotherapy 6 sessions (90806)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
847.2	90806		Prosp	6					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-17 pages

Respondent records- a total of 23 pages of records received to include but not limited to:
TDI letter 11.2.09; letters 9.24.09, 10.22.09; report 6.11.09; records, DO 6.24.09-8.27.09; MRI L-Spine 7.16.09; Injury Clinic note 8.28.09

Requestor records- a total of 34 pages of records received to include but not limited to: Injury Clinic records 8.28.09-11.6.09 TDI letter 11.2.09; request for an IRO forms; letters 9.24.09, 10.22.09; records Dr. 6.24.09-8.27.09; MRI L spine 7.16.09; report 6.11.09

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with the non-certification presented by Ph D. It is noted that the injured employee has a history of low back and bilateral lower extremity pain. This has been treated conservatively. There is some contradiction between the note and the mental health assessment in terms of the medications being employed. Dr. could not objectify the clinical evidence for this request and the necessity could not be established after speaking with the requesting provider. There was also concern about the veracity and objectivity of the pathology and complaints.

A reconsideration was filed and Dr. noted that the request was not consistent with the parameters established in the official Disability Guidelines.

Plain films of the lumbar spine (Dated June 11, 2009) noted posterior facet disease.

The clinical evaluation completed on June 24, 2009 by Dr. noted "severe low back pain and bilateral leg pain. Paravertebral muscle spasm was noted, as was a decreased range of motion and a positive straight leg raising. The diagnosis was a probable herniated lumbar disc with bilateral radiculopathy.

Lumbar MRI dated July 16, 2009 noted that there were no disc herniations or protrusions. There was no lumbar compromise. The follow-up physical examination (dated July 30, 2009) noted ongoing complaints of pain, compromise to ambulation and that electrodiagnostic studies were pending. This lady was continued on an off work situation.

There is a reference to a Designated Doctor evaluation noting that maximum medical improvement had not been reached.

An LPC intern at the Injury Clinic completed the psychiatric evaluation. The reported mechanism of injury was noted as was the presumed diagnosis (disproved by imaging study) and the assessment was a major depressive disorder, severe, single episode secondary to the work injury. An additional assessment was that every issue that this lady faced is a function of the work place injury. The intern felt that individual psychotherapy; CBT autogenic and progressive muscle relaxation, hypnotherapy and sleep therapy adjustment was needed. An additional consultation for psychotropic medications was suggested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines this is "recommended as option for patients with *chronic low back pain* and delayed recovery. Behavioral treatment, specifically cognitive behavioral therapy (CBT), may be an effective treatment for patients with chronic low back pain, but it is still unknown what type of patients benefit most from what type of behavioral treatment. Some studies provide evidence that intensive multidisciplinary bio-psycho-social rehabilitation with a functional restoration approach improves pain and function. ([Newton-John, 1995](#)) ([Hasenbring, 1999](#)) ([van Tulder-Cochrane, 2001](#)) ([Ostelo-Cochrane, 2005](#)) ([Airaksinen,](#)

[2006](#)) ([Linton, 2006](#)) ([Kaapa, 2006](#)) ([Jellema, 2006](#))” as identified by the two prior reviews, there is no competent, objective and independently confirmable medical evidence that this is a chronic problem or how this would assist this injured employee.

Given that there is a Designated Doctor evaluation noting that maximum medical improvement is not reached, and the changes noted on MRI are not consistent with the primary treating physician evaluation; there are a number of orthopedic issues that need to be resolved prior to declaring this a chronic pain situation needing individual psychotherapy. Therefore, the requested services are not approved as 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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)