

PRIME 400 LLC
240 Commercial Street, Suite D
Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 6, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Therapy (90806) 1 x per week x 8 weeks

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

M.D., Board Certified in Psychiatry and Neurology
Licensed by the Texas State Board of Medical Examiners

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.

The reviewer finds that medical necessity exists for Individual Therapy (90806) 1 x per week x 8 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 12/29/08, 1/21/09
ODG Guidelines and Treatment Guidelines, Pain
1/12/09, 12/22/08, 12/8/08
Dr. MD, 12/19/08, 10/14/08, 10/13/08, 10/11/08, 10/10/08, 9/8/08, 11/4/08

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a xx year who broke her ankle in a work related accident. She was initially felt to have a sprain, subsequently developed an infection and was found to have a fracture, nerve damage, and required surgery. An office visit note dated xx/xx/xx by, MD states the claimant reports having severe pain below the right knee with an L5 distribution complaint of a radicular quality. She had decompression surgery on her lower back in mid October 2008. She is diagnosed with Reflex Sympathetic Dystrophy, causalgia of the lower limb and dysthymia. The diagnosis of Dysthymia was determined by PhD on 12/8/2008. She appeared euthymic and displayed some pain behaviors, such as shifting in her chair, rubbing her right leg and walking with a limp. On rating scales, she was assessed as having minimal depression with medications and minimal anxiety. In an addendum, dated 1/12/2009, Dr. writes that claimant is unable to manage her ADL's, is active only 1-2 hours per day, has a poor quality of life and lives with constant pain. The priority of Dr. treatment is to help her work through some of the feelings of frustration and the overall losses in her life that resulted from her work-related injury. Claimant is also described as irritable, unable to get pleasure out of life, feels helpless and discouraged. Ph.D. reviewer, denied the request for 8 sessions of psychotherapy stating that the claimant had only negligible evidence of psychosocial distress and negligible evidence of depression or anxiety.

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

ODG Guidelines state that the identification and reinforcement of coping skills are often more useful in the treatment of pain than ongoing medication or therapy. The guidelines offer that if a patient shows lack of progress after PT alone, the patient should be given an initial trial of psychotherapy. According to the records presented for this review, this claimant's treating provider is trying to alleviate the claimant's pain to provide more relief despite a number of therapeutic measures, including nerve stimulation and surgery. Dr. addendum states that the claimant is suffering from frustration, hopelessness and poor quality of life. ODG Guidelines provide for an initial trial of behavioral therapy to help such a claimant develop coping skills for her disorder and pain. The reviewer finds that medical necessity exists for Individual Therapy (90806) 1 x per week x 8 weeks.

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)**