Advanced Medical Reviews

ACCREDITED EXTERNAL REVIEW

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 1/19/2009
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. Psychotherapy x 4 Weeks

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Missouri. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Psychology since 1977 and currently resides in CO.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

1. Psychotherapy x 4 Weeks Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Review organization dated 1/2/2009
2. Independent review organization dated 12/31/2008
3. Clinical note by, dated 12/5/2008
4. Clinical note by dated 12/30/2008
5. Case assignment by, dated 1/5/2009
6. Clinical note dated unknown,
7. Review organization by, dated 1/5/2009
8. Independent review organization dated 1/2/2009
9. Independent review organization dated 12/31/2008
10. Clinical note by, dated 12/5/2008
11. Clinical note dated 12/2/2008
12. Pre authorization request dated 12/2/2008
13. Patient face sheet dated 10/29/2008
14. Clinical note dated 11/8/2008
15. Consultation note by, dated 11/24/2008
16. Clinical note by, dated 12/30/2008
17. Clinical note dated 12/19/2008
18. Pre authorization request dated 12/19/2008
19. Patient face sheet dated 10/29/2008
20. Clinical note dated 11/8/2008
21. Preauthorization request by, dated 12/19/2008
22. Consultation by, dated 11/24/2008
23. Work status report dated 11/12/2008
24. Clinical note by dated 11/4/2008
25. CT cervical spine by MD, dated 10/23/2008
26. CT head without IV contrast by MD, dated 10/23/2008
27. Lumbar spine by MD, dated 10/23/2008

28. Patient evaluation dated 10/27/2008
29. Orthopedic testing dated 10/27/2008
30. Clinical note dated 10/26/2008
31. Clinical note by, dated 1/6/2009
32. Review organization by, dated 1/5/2009
33. Clinical note by, dated 1/5/2009
34. Patient face sheet dated 10/29/2008
35. Clinical note dated 11/8/2008
36. Request form dated 12/31/2008
37. Preauthorization request dated 12/2/2008
38. Environmental intervention by, dated 12/4/2008
39. Clinical note by, dated 12/5/2008
40. Preauthorization request dated 12/19/2008
41. Preauthorization request by, dated 12/19/2008
42. Environmental intervention by, dated 12/22/2008
43. Clinical note by, dated 12/22/2008
44. Consultation by, dated 11/24/2008
45. Clinical note by, dated 11/4/2008
46. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a xx year old female with a date of injury of xx/xx/xx. There is a two month history of low back and right lower extremity pain complaints following the fall with conservative care. The injured employee returned to work and is currently taking cyclobenzaprine and hydrocodone. The current request is for 4 sessions of individual psychotherapy.

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

The ODG suggests that psychological intervention is appropriate in cases where there is delayed recovery or treatment is necessary for chronic pain. Most authorities conclude that chronic pain has its onset at least three months following the initial injury. This employee was injured on xx/xx/xx when she fell and injured her neck, thoracic, and low back. She was evaluated about a month later on xx/xx/xx. Evidence of mild depression and moderate anxiety were obtained during this evaluation. In the interim the employee return to work. Based on these factors, the employee returning to work and the short time between her injury and initial psychosocial evaluation, there is no evidence that she had or could have developed chronic pain are displayed delayed recovery. Based on these factors, the denial of four sessions of individual psychotherapy was appropriate. It was also appropriately sustained during a reconsideration/appeal. The basis for denying the care was that there was no evidence of "delayed recovery". The provider requesting this IRO did not provide any additional evidence suggesting why the denial should be overturned or arguing against the idea of the absence of "delayed recovery" discussed by the two previous reviewers. The denial should be upheld. There is no basis to argue that the claimant was suffering from chronic pain are delayed recovery. Psychological treatment was not medically necessary and should have been denied.

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
X 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)

Name: Patient_Name

AMR Tracking Num: 105226