



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 7/17/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under review include 6 sessions of individual therapy.

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

The reviewer is a Ph D in Psychology and a licensed professional counselor. This reviewer has been practicing greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding 6 sessions of individual therapy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr.

These records consist of the following (duplicate records are only listed from one source): IRO request form, LHL 009, 6/22/09 request for IRO review by Dr. appeal letter of 5/7/09, 4/7/09 preauth letter, 3/26/09 behavioral medicine eval, appeal letter of 4/3/09, 4/17/09 denial letter, 5/14/09 denial letter, 6/25/09 email by 4/8/09 note by MD, 3/20/09 RME report by Dr. 6/29/09 email from 12/22/08 letter by MD, 1/3/09 letter by MD, HICFA 1500 form, DWC 69 form 11/20/08, DD report 11/20/08, 9/29/08 letter of clarification, 9/10/08 DWC 69 with report by MD, 5/20/08 note by Dr. 3/28/07 letter by Dr. , 2/28/08 RME report, 8/17/06 RME report and 11/17/05 RME report with DWC 73.

Dr. : no additional records were received that differed from the ones listed above.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a male who sustained a work related injury to the neck and right shoulder on xx/xx/xx while performing his customary duties . The patient reported that he had been employed with the company for approximately xx months at the time of the injury.

He was rear ended by an SUV. He did not go to the emergency room. He was unable to continue working and reported the injury to his employer.

On 7/13/05 the patient reported no pain in the lower back. On 7/13/05, he reported "no longer having problems with his shoulder." Most pain was in base of neck area. He reported low back pain at this time with no radiation. He also reported difficulty sleeping. He started receiving physical therapy 3-5 times per week on 8/15/05 which has continued 3X per week until and presumably through the most recent report. In August of 2005, he reported falling in the shower. His ratings of his pain have fluctuated considerably from 8-9 on a ten point scale to no pain reported to mild discomfort. Upon review of received medical records, he has reported no pain or mild discomfort in his lower back, right shoulder, and his neck.

The patient has had an MRI of the right shoulder, cervical spine, and lumbar spine. He had an ultrasound of the right shoulder, lumbar-SI and Cervical. He also had a nerve conduction study and discogram. Diagnoses following these evaluations were muscle strain/pain and showed no neuropathology, some degenerative damage in the lumbar and cervical spine. He has been prescribed Lortab, Tylenol 3, Xanax for sleep, Ambien, Motrin 800, Valium,

He denied ever having prior counseling or psychotherapy. He has not received individual therapy related to this injury to date as a request for such service was denied on 05/14/08. Results from several procedures administered on 03/26/2009 led PhD to the diagnosis of:

DSM IV

AXIS I	296.22 Major Depressive Disorder, Single Episode, Moderate 307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
AXIS II	V71.09 No diagnosis.
AXIS III	Cervical Disc Syndrome; Lumbar Discogenic Pain; Right Shoulder Rotator Cuff Tear
AXIS IV	Psychosocial Stressors: 3, Moderate Persistent Pain Producing Disruption of Psychological Functioning and Lifestyle Inadequate Finances
AXIS V	GAF= 58 (current)

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

The ODG indicates this therapy is recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work.

The provided medical records do not indicate that Mr. has complained of any psychological concerns in four years of medical treatment. He has been treated for insomnia and difficulty sleeping regarding pain. The only other mention of social/personal concerns in available records was noted when Mr. requested a prescription for Viagra. As no need or concerns for Mr. 's psychological well-being have been addressed for nearly four years and his current complaints of pain are minimal when asked verbally, the necessity of individual therapy does not prove warranted based on this injury. The reviewer indicates this does not correspond with an "appropriately identified patient" as per the ODG.

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)