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DATE OF REVIEW: 06/02/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: 6 sessions of individual psychotherapy

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

Texas Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Follow-up note dated 11/07/08
2. Report of medical evaluation dated 11/17/08
3. Neurological evaluation dated 11/17/08
4. Follow up note dated 01/05/09
5. Initial consultation dated 01/14/09
6. Partial mental health evaluation dated 03/25/09
7. Utilization review determination dated 04/02/09
8. Request for reconsideration dated 04/20/09
9. Utilization review determination dated 04/24/09
10. Letter dated 05/13/09
11. ***Official Disability Guidelines***

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was described as being a female with a date of injury of xx-xx-xx. On this date, the employee slipped and fell on a wet surface striking her head and the right side of her body. The employee reported a brief loss of consciousness; however, this was undocumented.

The employee was taken to a local emergency room with contusion of the head and right knee and neck sprain. X-rays were negative for the cervical spine and revealed a bipartite patella. A CT scan of the head was unremarkable.

An MRI of the right knee dated 09/07/08 reportedly revealed a bipartite patella, a medial collateral ligament strain, a mild medial compartment arthritic change, and no discreet meniscal tear was noted.

On 09/08/08, the employee underwent a neurological evaluation. The employee continued to complain of persistent pain from head to toe with pain particularly severe in the neck and low back.

The employee was released to return to work with respect to the right knee on 09/19/08.

An MRI of the lumbar spine dated 10/08/08 revealed mild degenerative disc disease at L4-L5 and L5-S1 with mild canal narrowing at L5-S1 with bilateral foraminal narrowing. A cervical spine study revealed mild degenerative disc disease at C5-C6 with associated mild cord indentation. An MRI of the brain was interpreted as negative.

The employee presented on 11/17/08 with complaints of blurred vision and headaches with numbness of the right arm and of the lower neck; pain in the low back with an inability to drive because of pain; and being depressed and easily fatigued. A report of medical evaluation dated 11/17/08 found the employee to have not reached Maximum Medical Improvement (MMI). Medications at that time were listed as Flexeril and Tylenol. The employee reportedly underwent a Lap-Band procedure in June, 2008 and had lost 20-30 pounds. The employee had been attending physical therapy and noted that it was somewhat helpful. The employee was recommended to undergo a psychological evaluation to assess if any psychological overlay was present.

The employee underwent an initial consultation with M.D., on 01/14/09. The employee complained of low back pain and discomfort as well as knee popping with intermittent neck pain and headaches as well; intermittent numbness of the right arm with pain radiating into the legs; coccygeal pain; urinary incontinence issues; swelling of the knee, and reported that she required the use of a cane for ambulation at that time. The employee reported that she was not currently working. The impression was reported as internal derangement of the right knee, lumbar radiculitis, cervical radiculitis, and urinary incontinence.

The employee underwent a mental health evaluation on 03/25/09. Current medications were listed as Darvocet N-100, Flexeril, Mobic, and Cymbalta. The employee reported headaches three to four times a week. The employee reported trouble with bladder control and continued to experience blurred vision. She reported fatigue, disturbed sleep, and irritability. The employee reported increased appetite and weight gain. She felt “hopeless” and was anxious “all of the time”. The employee did not feel that she had improved and was frustrated with the treatments she had received. The employee reported a very high subjective level of pain and was very focused on her symptoms. The employee felt that people were “out to get her”. Depression was noted in session and she was tearful. The remainder of the mental health evaluation was not submitted for review.

A previous utilization review performed on 04/02/09 determined that the requested individual psychotherapy was not medically necessary based on a lack of supporting documentation. Neurological symptoms were reported but not assessed. There has reportedly been no appropriate psychometric screening for cognitive loss. The documentation indicates that a neurological examination reported "symptom magnification", and the evaluation does not attempt to assess other factors that may be contributing to this employee's delayed recovery from injury.

A request for reconsideration dated 04/20/09 reported that the employee suffered cervical and lumbar disc injuries and fracture of the patella as the result of a fall. The employee's BDI was reportedly 40 and BAI is 38. The employee had poor pain and stress management skills per the request. It was felt that the employee would reportedly benefit from individual psychotherapy where techniques including cognitive behavioral retraining, stress reduction, goal setting, and training in pain management would be utilized to help the employee come to terms with her circumstances, better manage her pain and pain related stress, and to reduce her injury related depression and anxiety.

A subsequent utilization review performed on 04/24/09 also non-authorized the requested six sessions of individual psychotherapy, noting that additional information was not provided to address the issues raised in the initial review of the request. Dr. reportedly indicated the employee did not evidence neurological deficits, but the employee had been referred twice for a neurological evaluation.

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

I am in agreement with the two previous reviewers that six sessions of individual psychotherapy are not considered medically necessary for this employee. The employee reports severe levels of depression and anxiety; however, the submitted records indicate that the employee underwent a Lap-Band procedure in June, 2008. Prior to undergoing this procedure, the employee would have been required to undergo a psychological evaluation to assess any possible confounding issues. Clearly, the employee was determined to be stable enough from a psychological standpoint to undergo the Lap-Band procedure.

This certainly raises questions regarding the validity of the employee's current complaints and raises issues of malingering and exaggeration of symptoms. The employee's subjective complaints appear to far outweigh any objective findings in the submitted medical records, and as such, six sessions of individual psychotherapy are not warranted for this employee.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. ***Official Disability Guidelines***, Return To Work Guidelines (2009 *Official Disability Guidelines,* 14th Edition) Integrated with Treatment Guidelines (*ODG Treatment in Workers' Comp,* 7th Edition) Accessed Online