

IRO REVIEWER REPORT

DATE OF REVIEW: 11/30/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

90806 Individual Counseling 2x wk x3wks, 1 unit per session

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

The TMF physician reviewer is a board certified - licensed (specialty) with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the 90806 Individual Counseling 2x wk x3wks, 1 unit per session is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 11/12/09
- Letter of review outcome – 09/22/09, 10/15/09
- Independent review organization summary – 11/16/09
- Employers first report of injury or illness – xx/xx/xx
- Notice of disputed issue(s) and refusal to pay benefits

- Management, Inc. – 09/08/09, 09/24/09, 10/19/09
- Associate statement – Workers Compensation – xx/xx/xx
- Texas Workers Compensation Work Status Report – xx/xx/xx
- Report of examination by Healthcare System – 06/22/09, 08/25/09, 09/08/09, 10/09/09
- Healthcare Systems Daily Progress & Therapy Notes – 06/26/09 to 08/19/09
- Electrodiagnostic Testing results – 07/03/09
- Emergency Department record from Hospital – 07/06/09
- Examination findings by Dr.– 07/08/09 to 08/05/09
- Physical performance evaluation by Dr. – 07/08/09
- Report of MRI of the cervical spine – 07/14/09
- Report of drug screening – 07/23/09 to 09/02/09
- History & Physical by Dr.– 07/29/09 to 08/20/09
- Examination Finding by Dr. – 09/02/09 to 10/21/09
- Psychological evaluation by Dr. – 09/10/09
- Consultation by Dr.– 09/25/09
- Solutions Report – 10/02/09
- Request for appeal from Dr. – 10/08/09
- Request for pre-certification by Dr. – 09/17/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx . The patient has been treated with medications and physical therapy. She still complains of burning, sharp, shooting and stabbing pain. The treating chiropractor referred the patient for psychological evaluation and the request is for 90806 Individual Counseling 2x wk x3wks, 1 unit per session.

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

Individual counseling is medically necessary for this patient. She has exhausted treatment and continues to have a significant avoidance to activities for fear of exacerbated pain and re-injury. Her pain is affecting her psychological state including depression and anxiety. OGD guidelines state that separate psychotherapy is medically indicated when the patient lacks recovery from physical therapy alone who also presents with high fear avoidance tendencies. The sessions can work on reducing irrational fears towards re-injury, identify negative and maladaptive coping strategies such as smoking, inactivity and irrational fears and implement a variety of self regulation, coping, stress

management and pain management strategies to control subjective distress and replace positive strategies in place of negative strategies currently used. Goals will include stabilization of depression and anxiety to moderate levels, reduce fear toward activity with reported increased daily activity levels and reduce FABQ scores.

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)