



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/26/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The service under dispute is 6 sessions of outpatient individual psychotherapy sessions.

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

The reviewer is a Ph D with a specialty in Psychology and Counseling. This reviewer has been practicing for greater than five 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 the prospective medical necessity of 6 sessions of outpatient individual psychotherapy sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): 1/19/09 MRI of right foot, 2/17/09 right foot and ankle radiographic reports, FCE of 7/9/09, ED physician note of 11/1/08, 11/11/08 handwritten chart note, PT notes and evaluations of 11/12/08 to 5/01/09, 11/18/08 to 2/20/09 reports by MD, 12/30/08 to 3/24/09 notes by MD, MD reports and progress notes from 2/17/09 to 8/5/09, 3/10/09 operative note, 7/2/09 letter by DC, handwritten SOAP notes 7/9/09 to 9/28/09, 9/10/09 Residual FC battery and outcomes assessment reports, DWC 69 with report 3/26/09,8/7/09 DWC 69 and report and 9/11/09 impairment code report .

10/2/09 handwritten note, LPC report of 8/28/09, handwritten SOAP notes 8/21/09 to 10/2/09, request for WH 9/25/09, 9/28/09 outcomes assessment for foot and 2/17/09 addendum to right ankle MRI report.

Forte: denial letters of 9/24/09 and 10/1/09 and MD peer review (pg 1 of 5).

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient, a female, sustained a compensable work related injury to her right foot on xx/xx/xx while performing her customary duties . She slipped and fell on a wet floor and twisted her foot. She reported pain in her foot almost immediately which became worse with time. She returned to work at light duty for a while, but is not presently working. She was seen in the emergency room two days later. X-rays showed no dislocations or sprains or fractures.

She received a lumbar sympathetic block on March 10, 2009. She reported feeling no pain following the procedure although she began reporting pain on follow-up visits with her doctors. On pain questionnaires, she reported almost all pain and life disruptions as 8-9 on a scale of 1-10. She reported suicidal ideation during her psychotherapeutic evaluation with XXXX XXXXX LPC, PhD who is requesting the psychotherapy services.

The patient has a 9th grade education and no prior history of surgeries besides a hysterectomy approximately two years prior to this injury. She is of a proportionate weight for her height and has no other identified medical conditions. She endorsed frustration with her work place for interfering with her doctor's orders of limited duty work and use of crutches.

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

Although as described in the 2007 Official Disability Guidelines :*“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 request for psychotherapy did not include an evaluation of the patient's current mental health status. No records or results from psychological screenings or evaluations such as the Beck Depression Inventory or other evaluative tools were noted. It is not therefore clear how the diagnosis was derived at nor is the plan for treatment outlined or discussed; therefore, the disputed service is not medically reasonable and necessary based on the medical records provided.

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)