



**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 08/11/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Psychotherapy 1 x Wk x 6 Wks

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

Diplomate of American Board of Psychology and Neurology
Board Certification in Psychiatry, Addiction and Forensic Psychiatry, and Pain Medicine

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.

Individual Psychotherapy 1 x Wk x 6 Wks - OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Case Management and Treatment, Unknown Provider, Undated
- MRI Left Shoulder, M.D., 04/12/10
- Note, Treatment Clinic, 05/01/10, 06/11/10
- Initial Report, Treatment Clinic, 05/19/10
- Initial Orthopaedic Consultation, M.D., 05/28/10
- Initial Interview, 06/15/10
- Request for Individual Psychotherapy Sessions,, 07/02/10
- Denial Letter, 07/07/10, 07/15/10
- Request for Reconsideration,, 07/08/10
- Request for Medical Dispute Resolution, 07/23/10
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

It was noted the patient tripped and fell, dislocating the left shoulder. An MRI of the left shoulder indicated a full thickness rotator cuff tear. He had undergone six sessions of physical medicine and rehabilitation with good results. It was later stated the patient felt continuous severe pain and was unable to continue with the demands of his job. He was referred for an evaluation to determine the appropriateness of psychological therapy. It was recommended that he attend six sessions of individual psychotherapy to address high levels of stress and depressive symptoms to help increase the management of his severe pain.

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

The individual psychotherapy one time a week for six weeks is reasonable and necessary. The claimant is a male who suffered a dislocation of his right shoulder with associated full thickness tear of his rotator cuff. The injury occurred on xx/xx/xx. Subsequent to the injury, he has had increasing symptoms of anxiety and depression as documented on the initial interview from dated 06/15/10. The diagnosis at that time was adjustment disorder with mixed anxiety and depressed mood and pain disorder with both psychological factors and the general medical condition. The ODG web-based guidelines for adjustment disorder with anxiety and depressive mood referred to cognitive therapy for depression where an initial trial of six visits over six weeks is recommended and with evidence of objective functional improvement, a total of up to thirteen to twenty visits over thirteen to twenty weeks of individual sessions. The request for individual psychotherapy one time a week for six weeks is consistent with ODG web- based guidelines and is medically necessary and reasonable based upon the records reviewed.

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 KNOWLEDGBASE
- 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)