

Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual psychological sessions at one (1) per week for six (6) weeks, for a total of six (6) sessions

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

MD, Psychiatrist, Certified by the American Board of Psychiatry and Neurology

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

The Company, Non-authorization Letters, 12/29/09, 1/29/10

Injury 1/22/10

Health 12/11/09, 11/23/09, 12/23/09, 1/22/10

Addendum, Results of BDI-II, and BAI, 12/11/09

M.D. 5/5/03

Health Patient Face Sheet, 12/1/09

ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

THIS MALE PATIENT WAS INJURED ON xx/xx/xx WHEN HE BENT DOWN TO PICK UP A HEAVY RAMP, CAUSING INJURY TO THE CERVICAL AND LUMBAR SPINE AND RIGHT SHOULDER. HE HAD ARTHROSCOPIC REPAIR OF THE ROTATOR CUFF ON 7/8/2003 AND ANOTHER ARTHROSCOPIC REPAIR OF THE RIGHT ROTATOR CUFF ON 1/27/2004. HE ATTENDED PHYSICAL THERAPY FROM JUNE UNTIL DECEMBER 2004. HE ATTENDED A WORK HARDENING PROGRAM IN AUGUST 2006 AND PARTICIPATED IN 30 DAYS OF A CHRONIC PAIN PROGRAM IN 2006. HE COMPLETED A TOTAL OF 2 SESSIONS OF INDIVIDUAL PSYCHOTHERAPY AND PARTICIPATED IN GROUP THERAPY AS PART OF HIS WORK HARDENING PROGRAM. HE HAS NOT HAD ANY OTHER MENTAL HEALTH TREATMENT OR PSYCHOPHARMACOLOGICAL TREATMENT ACCORDING TO THE RECORDS. A MENTAL HEALTH ASSESSMENT ON 12/11/2009

FOUND HIM TO BE DYSPHORIC, AFFECT CONSTRICTED, PSYCHOMOTOR RETARDATION AND WITH PASSIVE SUICIDAL IDEATION. HE HAD HIGH SCORES IN IRRITABILITY AND RESTLESSNESS, FRUSTRATION AND ANGER, MUSCLE TENSION/SPASM, NERVOUSNESS AND WORRY, SADNESS AND DEPRESSION AND SLEEP DISTURBANCE AND FORGETFULNESS. HE HAS BEEN GIVEN A DIAGNOSIS OF PAIN DISORDER ASSOCIATED WITH BOTH PSYCHOLOGICAL FACTORS AND A GENERAL MEDICAL CONDITION, SECONDARY TO THE WORK INJURY. A REQUEST HAS BEEN MADE FOR 6 SESSIONS OF INDIVIDUAL PSYCHOTHERAPY TO HELP THE PATIENT'S MOOD AND REDUCE HIS EMOTIONAL DISTRESS.

SPECIFIC TREATMENT GOALS AND OBJECTIVES ARE LISTED IN THE RECORDS BY THE TREATMENT TEAM OF PH.D. AND PH.D. THE REQUEST WAS DENIED STATING "THERE IS NO DISCUSSION OF WHAT HAS TRIGGERED THIS RETURN, WHETHER HE IS USING THE SKILLS HE WAS TAUGHT IN EXTENSIVE PRIOR BEHAVIORAL CARE, AND IF NOT, WHY NOT. THERE IS NO RELAPSE PREVENTION PLAN. HE IS NOT ON ANY ANTIDEPRESSANTS. THE CASE IS PRESENTED AS IF HE NEVER RECEIVED SUCH CARE IN THE PAST. THERE IS NO CLEAR RATIONALE FOR STARTING OVER AGAIN GIVEN THE EXTENSIVE COGNITIVE BEHAVIORAL INTERVENTIONS HE HAS ALREADY RECEIVED."

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

WHILE THIS PATIENT RECEIVED GROUP THERAPY AS PART OF A WORK HARDENING PROGRAM IN 2006 AND HAS RECEIVED 2 SESSIONS OF INDIVIDUAL THERAPY, THIS REQUEST IS BEING MADE MORE THAN 3 YEARS LATER. THIS REVIEWER DISAGREES WITH THE PRIOR REVIEWER THAT THE PATIENT'S PREVIOUS TREATMENT QUALIFIES AS "EXTENSIVE PRIOR BEHAVIORAL CARE."

THE PRIOR REVIEWER CRITICIZES THE LACK OF A "RELAPSE PREVENTION PLAN". HOWEVER, RECORDS DEMONSTRATE THIS PATIENT HAS ALREADY RELAPSED, AND THE CURRENT REQUEST FOR SERVICES IS PART OF THE CURRENT TREATMENT TEAM'S PLAN TO DEAL WITH HIS RELAPSE.

ODG GUIDELINES STATE THAT CBT CAN BE AS EFFECTIVE AS MEDICATION IN TREATMENT OF DEPRESSION. THE PATIENT CONTINUES TO HAVE CHRONIC PAIN AND IS UNABLE TO WORK. THE RECORDS REVIEWED DEMONSTRATE THIS PATIENT SATISFIES THE ODG FOR 6 SESSIONS OF INDIVIDUAL PSYCHOTHERAPY. UPON INDEPENDENT REVIEW, THE REVIEWER FINDS THAT THE PREVIOUS ADVERSE DETERMINATION(S) SHOULD BE OVERTURNED. THE REVIEWER FINDS THAT MEDICAL NECESSITY EXISTS FOR INDIVIDUAL PSYCHOLOGICAL SESSIONS AT ONE (1) PER WEEK FOR SIX (6) WEEKS, FOR A TOTAL OF SIX (6) SESSIONS.

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

ACOEM-AMERICA 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)