
Notice of Independent Review Decision

DATE OF REVIEW: 10/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1 x 6 weeks

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

The physician providing this review is Board Certified, American Board of PM/Occupational Medicine and Board Certified, American Board of Emergency Medicine. Her primary practice is Occupational medicine. She is in active practice and has practiced medicine for 24 years. This reviewer is licensed in the state of Texas.

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.

No. The request for individual psychotherapy x 6 visits is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records received: 2 page fax and a 14 page fax on 9/23/2010 IRO request, a 67 page fax and a 156 page fax on 9/27/2010 Response to disputed services including administrative and medical records.

PATIENT CLINICAL HISTORY [SUMMARY]:

The documentation begins with an Employer's First Report of Injury dated xx/xx/xx that states the claimant injured her left shoulder on xx/xx/xx while turning a plastic bag carousel. She was evaluated on December 21, 2007 by, PA-C and complained of left shoulder pain with occasional radiculopathy to the biceps region. She was diagnosed with a left shoulder strain and was given medications and placed on a limited duty for one week. She was expected to return to full duty on December 28, 2007.

On August 20, 2008, she was evaluated by, PA and had attended physical therapy. She had continued to work full time but the physical therapist recommended that she go on disability because she seemed to be making the shoulder worse and physical therapy was described as counterproductive. She received FMLA paperwork to give her a month off so she could concentrate on physical therapy. She was prescribed Flexeril and x-rays and MRI of the left shoulder were ordered. X-rays of the left shoulder dated August 20, 2008 were unremarkable. An MRI of the left shoulder dated August 27, 2008 showed a paralabral cyst but no evidence of a rotator cuff tear.

On September 19, 2008 she was seen by Dr. and stated that her shoulder was getting worse. She had been off for about a month and was taking Flexeril and Tylenol. She had also had cortisone shots x 2 to the left shoulder which had improved her pain and had done physical therapy. She thought that her shoulder was a little loose in the socket. She was in no acute distress and was moving her shoulder a lot. She was able to make a loud popping sound with the left shoulder as she moved the humerus around in the socket. Palpation

of the supraspinatus and rotator cuff muscles was not significantly tender. The diagnosis was left shoulder strain and a left shoulder arthrogram was recommended. She was placed on restricted work.

On October 3, 2008, she saw Dr. for her left shoulder and continued to have pain. She was continuing to use medications. She complained of new onset right shoulder pain that she blamed on overuse of that shoulder since the left shoulder was injured. Her left shoulder arthrogram was pending and she remained on restricted work. On October 10, 2008, she saw Dr. again and continued to have soreness about the shoulder. Her right shoulder was also popping similarly to the left shoulder. She presented for a medication recheck. On October 28, 2008, she saw Dr. again and was waiting for an MR arthrogram which was scheduled on November 3, 2008. She had occasional pain mostly at work but was doing much better. She had full range of motion of the left shoulder in terms of her overhead reach with some reported mild discomfort and had pain in the joint itself. She continued work restrictions.

The MRI dated November 3, 2008 revealed a SLAP lesion with associated paralabral cyst in the spinoglenoid notch. On November 5, 2008, Dr. referred her to Orthopedics and she saw, PA on November 24, 2008. The diagnosis was superior labrum anterior – posterior lesion and she was referred to an orthopedic surgeon for arthroscopic labral evaluation and repair.

She was evaluated by Dr. on November 25, 2008 for her left shoulder. Arthroscopic surgery for decompression of the cyst and repair of the superior labrum was done on December 22, 2008. She was offered temporary alternative duty in January 2009.

On February 3, 2009, she saw Dr. for follow up and she still had some pain in her shoulder and was using an immobilizer. She felt she was recovering. She was advised to start gentle range of motion exercises. On March 6, 2009, she saw by Dr. and was doing range of motion therapy at home and had occasional pain in her shoulder. A rehab program was recommended. Dr. stated on June 9, 2009 that she did not attend the postop clinic appointment on April 7, 2009 and no further appointments were scheduled. The approximate recovery period for shoulder surgery is three to six months, and she was dismissed from care as she had not followed up postoperatively. She had reached MMI (maximum medical improvement).

On October 29, 2009, she saw Dr. and her left shoulder recently had started popping again. She had well-healed arthroscopic portals and good range of motion with a little pain on full elevation and internal and external rotation. She had normal sensation, normal strength and stability, and he felt she may have a possible re-tear of the superior labrum. The claimant was referred to rehabilitation which started on June 16, 2010. She demonstrated a flare-up of the injury with possible subacromial bursitis and persistent tear of the left labrum.

On June 17, 2010, she saw Dr. for pain in her left shoulder and she had marked pain and tenderness over the posterior aspect of her shoulder. The impression was left shoulder labral tear status post repair, rule out recurrent rotator cuff tear. On June 24, 2010, she saw Dr. again. She was not working; PT and psychiatric evaluations were advised. A repeat MRI of the left shoulder was recommended.

On July 1, 2010, she saw Dr. again and his impression was labral tear status post surgical repair with left shoulder sprain and chronic pain in the left shoulder. He stated she had frozen left shoulder due to pain. She had marked pain and tenderness and markedly decreased range of motion with pain radiating down her left arm. She also had some muscle atrophy in the left biceps and triceps. Physical therapy was recommended. The claimant was referred for an initial behavioral medicine consultation and saw, M.S. on July 20, 2010. The purpose was to evaluate her emotional status and subjective pain and determine the relationship to her work accident and her suitability for progression to some sort of low level behavioral treatments. She described pain levels at 8/10 which interfered with her recreational, social, and familial activities. Her

current level of functioning was described as 50%. She reported difficulty sleeping and got fragmented sleep. She relied on her medication and tried not to use her left shoulder or arm due to the pain. Her mood was dysthymic and her thought content indicated that she minimizes problems. She felt highly irritable and restless, had frustration and anger, muscle tension/spasm, nervousness and worry, sadness and depression, and forgetfulness and poor concentration. Her diagnoses included pain disorder with psychological factors and a general medical condition with chronic injury to the left shoulder. She demonstrated some depression and helplessness and treatment was advised as a brief low level of individual psychotherapy for six weeks. She scored an 8 on the Beck Depression Inventory–II indicating minimal depression and a 5 on the BAI, Beck Anxiety Inventory which indicated minimal anxiety. She showed significant fear avoidance of physical activity in general but did not show significant fear avoidance for work.

On July 29, 2010, she saw Dr. and still had a moderate amount of pain in her left shoulder. She wanted a full work release so that she could go back to work. She had good range of motion and very minimal pain to palpation and neurological examination was nonfocal. He stated that she may have adhesive capsulitis of left shoulder. A full duty release to work was recommended in addition to therapy for adhesive capsulitis, and she was given medication for pain.

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

The request for individual psychotherapy x 6 visits is not medically necessary. The claimant underwent a behavioral medicine evaluation on 07/2010 and was found to have difficulties in her daily activities but minimal anxiety and depression. Nine days later, on 07/29/10, she requested to return to her regular job. Dr. documented that she had a moderate amount of pain but had fairly good range of motion. She had had very minimal pain to palpation and an unremarkable neurologic examination. She was cleared to return to work and was to attend PT for adhesive capsulitis. There was no documented evidence of an inability to continue with the treatment plan and she appeared to be doing well. The medical necessity of the 6 visits has not been clearly demonstrated.

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)

REFERENCE:

Official Disability Guidelines, 2010. Pain Chapter: States “psychological evaluations may be recommended based upon a clinical impression of psychological condition that impacts recovery, participation in rehabilitation, or prior to specified interventions (e.g., lumbar spine fusion, spinal cord stimulator, implantable drug-delivery systems). Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation.”