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Notice of Independent Review Decision

DATE OF REVIEW: February 14, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy six sessions

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

International Neuropsychological Society
American Psychological Association

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Inc.:

- Office visits (01/06/10 – 07/22/11)
- Hip injection (12/02/10)
- Psychological evaluation (11/07/11 – 12/23/11)

Behavioral Health:

- Office visits (09/16/10 – 07/22/11)
- Hip injection (12/02/10)
- Psychological evaluation (11/07/11 – 12/23/11)

TDI:

- Utilization reviews (12/05/11 – 01/05/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who slipped on a belt loader exiting a plane on xx/xx/xx. She developed a sharp pain radiating from her left hip to her fingertips and from her left hip to her toes.

No records are available from the date of injury.

2010: The records start with evaluation by D.C., dated January 6, 2010. The patient presented for follow-up of her left hip, fracture of the neck of left femur and left pelvic injury. She complained of increasing pain with any type of prolonged sitting, standing or use of the left lower extremity and nocturnal pain. The patient was utilizing over-the-counter (OTC) medications. Examination revealed left hip strength at 4+/5 reduced secondary to pain, myofascial irritation particularly along the piriformis and gluteus medius lining and positive Fabere-Patrick's on the left. Dr. diagnosed resolving left hip fracture, left hip myofascial pain syndrome and irritation syndrome, resolved left sacroiliac (SI) joint dysfunction and lumbar sprain-strain. He recommended continuing medication management per Dr. and authorization for trochanteric bursal injection. The patient had regular follow-ups with Dr. who recommended evaluation at for ongoing chronic pain level, depression and altered mood and referred her to Dr. for determination regarding interventional pain management.

M.D., a pain management physician, evaluated the patient for ongoing left hip pain secondary to a stress fracture in the left hip unrelated to Workers Comp injury. History was positive for breast cancer and the patient was scheduled for mastectomy. She was utilizing Glucophage, Actos, Claritin, Flonase, Flector, Voltaren, a multivitamin, baby aspirin and Biofreeze. Review of systems was positive for joint and back pain. Examination of the left hip revealed pain with flexion and extension and tenderness over the left trochanter. Dr. reviewed magnetic resonance imaging (MRI) of the left hip (with supplemental pelvis) from 2008 that showed small stress fracture along the medial aspect of the left femoral neck and intertrochanteric region. Dr. assessed left hip pain and history of small stress fracture femoral neck and recommended an intra-articular steroid injection. Dr. noted that the injection was denied.

In October, Dr. noted that the patient had a left intra-articular injection and arthrogram on September 27, 2010. The patient received roughly 60% to 70% relief and was happy with the pain relief and most of her groin area pain had been alleviated. She complained of some pain behind the hip in the gluteal region on the left side and muscle spasm. Examination of the left hip revealed pain with flexion and extension, decreased tenderness, some left-sided gluteal muscle spasm and tenderness over the trochanteric bursa. Dr. assessed left hip pain and history of small stress fracture in the femoral neck status post left hip intra-articular injection with 60-70% relief. He recommended left trochanteric bursa injection with some accompanying trigger points in the gluteal muscles and continuing Voltaren, Flector patches and Biofreeze.

On December 2, 2010, Dr. performed left hip intra-articular injection and arthrogram and left trochanteric injection. Dr. noted slight improvement and recommended two sessions of physical therapy (PT).

In March 2011, the patient attended one session of PT. Dr. noted gradual improvement with daily activities and with the post injection process.

On follow-up, the patient complained of ongoing general discomfort increased with daily living activities. Examination revealed decreased strength in the left

hip and lumbar spine secondary to pain, left SI joint showing positive sciatic notch test and Nachlas, some palpatory trigger points within the left gluteal medius, piriformis and tensor fascia lata. Dr. recommended follow-up examination with Dr. for determination regarding additional interventional pain management and home exercise program (HEP). He also recommended continuing use of her electrical muscle stimulation (EMS) and transcutaneous electrical nerve stimulation (TENS) unit and referred the patient to for psychological care to help her address chronic pain management issue and integration with DARS.

On November 7, 2011, the patient was evaluated at Behavioral Health Associates, Inc., by LPC, who noted the following treatment history: *The patient was initially evaluated at Clinic. They checked her vitals and sent her home reporting they found nothing wrong with her. She continued to hurt and Dr., a pain management doctor, obtained x-rays of her hip revealing fractured hip. M.D., recommended internal fixation and referred her to Dr. Trick for evaluation and treatment. Dr. recommended bone scan. M.D., diagnosed left hip bursitis, possible left sacroiliac (SI) inflammation, as well as healed stress fracture of left hip. Dr. recommended continuing HEP to include aquatics which she felt was very beneficial for her at that time.*

The patient had x-rays of the lumbar spine with flexion and extension views that showed instability at L5-S1 with extension angle measuring 26 degrees with a 7mm retrolisthesis in extension with facet subluxation and foraminal stenosis; pelvic x-rays showed hips without degenerative joint disease (DJD) and sacroiliac (SI) joints without sclerosis. Bone scan of the left hip showed intertrochanteric left femoral neck stress fracture. MRI of the right hip and pelvis revealed right base of the femoral neck fracture on the right. MRI of the hip with supplemental pelvis revealed bone marrow edema along the medial aspect of the left femoral neck and intertrochanteric region, findings compatible with a small stress fracture. MRI of the lumbar spine was unremarkable. A physical performance evaluation (PPE) placed the patient at medium physical demand level (PDL) versus very heavy PDL required by her job. A recommendation was made to continue with a multidisciplinary program. A subsequent functional capacity evaluation (FCE) showed that the patient was unable to return to work and would benefit from active therapy.

On February 13, 2009, Dr. opined that the lumbar spine injury was a result of the incident on xx/xx/xx, and she was a candidate for chronic pain management program (CPMP). On a subsequent evaluation, Dr. opined that the patient could benefit from participation in a return to work program. D.C., assessed clinical maximum medical improvement (MMI) as of December 19, 2008, with 9% whole person impairment (WPI) rating.

The patient had been treated with PT with active modalities, home therapy program, TENS unit, massage, heat and mild stretching generally, 15 sessions of individual psychotherapy, 10 days of CPMP, epidural steroid injections (ESI) and left hip bursa x4.

The patient reported that her job description or responsibilities included loading and unloading cargo from the plane, loading and unloading luggage from the plane, servicing the plane and a wing walker. There was extreme job stress or

pressure for speed, perfection and production. The patient believed her medical symptoms, problems and/or disabilities would be very much permanent. The patient scored 19 on Beck Depression Inventory (BDI) consistent with moderate-to-severe depression. There was decrease by 3 points from her prior score of 22. On Beck Anxiety Inventory (BAI), the patient scored 16 consistent with mild levels of anxiety. The score was decreased from a prior score of 24. The patient was diagnosed with pain disorder associated with work-related injury medical condition and psychological factors and acute adjustment disorder with mixed anxiety and depressed mood and occupational problem. She was recommended six sessions of individual psychotherapy.

Per utilization review dated December 5, 2011, the request for six sessions of individual psychotherapy were denied with the following rationale: *“EE is a y.o. woman who reportedly was injured on xx/xx/xx. Lumbar MRI dated March 8, 2008, was normal. She has been under the care of D.C., since at least July 21, 2009, at which time he reported EE c/o LBP and left hip pain rated 1-2/10 in intensity. She underwent individual psych, injections and a WC program. On initial psych evaluation dated September 10, 2008, BDI was reported to be 23 and BAI was reported to be 38. McGill score was 60. On follow-up psych evaluation dated November 12, 2008, BAI was reported to be 14 and was reported to be 47. BDI was reported to have decreased but no score was provided. On FU with Dr. dated July 22, 2011, EE reported her pain to be 1.5-4/10. On September 22, 2011, Dr. reported that EE's pain was 2-4/10 and that she had undergone mastectomy for breast cancer. He reported that "this process is just about done and the patient is feeling much better with it. With this in mind, the patient is now able to increase her daily living activities and her independent home exercise program". He indicated that EE remained OOW. He recommended referral "for psychological care to help her address her chronic pain management issue and integration with DARS". Psych evaluation dated November 7, 2011, reported that EE has undergone 15 sessions of individual psych and 10 sessions of CPMP. It was reported that EE had improved but was not eligible for DARS at that time "due to co-morbid issues unrelated to her worker's compensation". EE's only medication was Celebrex (other than Actos and tamoxifen). BDI was 19, BAI was 16 and McGill was 36. It was recommended that EE undergo individual psych to "focus on vocational planning as [EE] is now able to move forward in her treatment for her work injury". I recommend non-certification of the request for the following reasons: 1. The ODG TWC 2011 Low Back chapter recommends an initial trial of 3-4 psychotherapy visits over two weeks and with evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks. In this case, EE has already had individual psych and, according to the records, her psychological testing scores have improved on their own without further sessions since the last re-evaluation. Therefore no formal therapy can be supported. 2 EE has already completed a CPMP.”*

In response to the denial letter, Ms. opined that an initial trial of six sessions over six weeks with evidence of objective functional improvement was appropriate and the literature supported six major patient variables that included social support, problem complexity and chronicity, personality reactivity and coping styles and treatment setting. She felt that the patient would benefit from participation in individual counseling in order to help her cope with the feelings attributed to her work-related injury and related stressors in the area of physical health.

Per reconsideration review dated January 5, 2012, the appeal for six sessions of individual psychotherapy was denied with the following rationale: *“The patient is a female whose date of Injury is xx/xx/xx. The injury is described as a result of slipping on a belt loader. She has had a fractured left hip. Therapies were put on hold due to cancer treatments and a mastectomy. The patient has completed her radiation/chemo treatment and is able to move forward with the work-related injury and is able to increase her ADLs and independent home exercise program (HEP). Dr. recommended referral for psychological care to help address chronic pain management issues and integration with DARS which was received on March 25, 2011. The December 23, 2011, note revealed a score of 19 on the Beck Depression Inventory, a score of 16 on the Beck Anxiety inventory, a score of 37 on the Sleep Questionnaire and reports waking up during sleep, cannot stop thinking while lying in bed, gasping for air during sleep, and that sleep does not seem refreshing. As per December 15, 2011, note, the patient complains of mood disturbances, anxiety disorder, sleep disorder, vocational concerns psychological factors. Treatments to date include PT, chiropractic treatments, a home exercise program, injections, ESIs, 15 psychotherapy sessions, work conditioning program, 10 sessions of a chronic pain program, a TENS unit, and medications. The reason for referral is medical necessity of six sessions of individual psychotherapy over eight weeks. The attending is appealing the request for six sessions of individual psychotherapy over eight weeks. However, there were no therapy progress reports to rationalize additional visits with documentation of positive gains from the prior psychotherapy sessions. This is necessary to validate that improvements in psychometric parameters are directly attributable to the rendered sessions. This is especially pertinent since the December 5, 2011, document reported that the patient's scores have improved on their own without further sessions since the last re-evaluation. At this point in time, the medical necessity of this request is not fully established.”*

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

THE CLAIMANT APPEARS TO HAVE BEEN TREATED PER THE ODG FOR HER CHRONIC PAIN FROM PRIMARY TO TERTIARY TREATMENT. IN THAT TREATMENT SHE HAS HAD 15 SESSIONS OF INDIVIDUAL PSYCHOTHERAPY BETWEEN 9/08 AND 9/09 WHICH REPORTEDLY WERE HELPFUL TO HER, THOUGH NO RECORDS WERE PROVIDED. SHE ALSO COMPLETED 10 SESSIONS OF A CHRONIC PAIN MANAGEMENT PROGRAM, A TERTIARY LEVEL OF TREATMENT, IN 4/09.

FROM THE CHAPTER ON THE TREATMENT OF CHRONIC PAIN IN THE ODG IT IS RECOMMENDED:

(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program, the evaluation should clearly indicate the necessity for the type of program required, and providers should determine up-front which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

THERE IS LITTLE EVIDENCE TO SUGGEST THAT CONTINUED PSYCHOTHERAPY WOULD BE POTENTIALLY EFFECTIVE AFTER A MORE INTENSIVE TERTIARY CHRONIC PAIN MANAGEMENT PROGRAM WAS COMPLETED AND YET WAS NOT EFFECTIVE. DUE TO THE LACK OF POTENTIAL EFFECTIVENESS OF 6 ADDITIONAL SESSIONS OF INDIVIDUAL PSYCHOTHERAPY, THE REQUEST DOES NOT MEET THE ODG FOR MEDICAL NECESSITY.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**