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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 90806 Psytx Off 45-50 Min, 99212 Office Outpatient Visit Est, 99220 Initial Observation Care

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Family Practice

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 medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for 90806 Psytx Off 45-50 Min, 99212 Office Outpatient Visit Est, 99220 Initial Observation Care cannot be supported as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO dated 11/30/12
Receipt of request for IRO dated 12/04/12
Utilization review determination dated 11/06/12
Utilization review determination dated 11/28/12
Behavioral medicine evaluation dated 10/10/12
DWC form 69 dated 11/20/12
Impairment rating dated 11/20/12
Reconsideration for behavioral health treatment dated 11/21/12

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a female who is reported to have a date of injury of xx/xx/xx. It is reported that the claimant developed cervical and left shoulder pain while installing car parts in an assembly line. Records indicate that the claimant was initially seen where she was provided oral medications and taken off work for 1 week. She was later seen who prescribed physical therapy and referred her for MRI and EMG. MRI is reported to have shown discopathy at multiple levels and EMG of the upper extremities is reported to have revealed cervical radiculopathy. She later underwent a course of cervical epidural steroid injections. The claimant was later recommended to undergo surgical intervention. Surgery was not approved and the claimant was apparently placed in a work hardening program. She did not progress and was subsequently recommended to transition to a chronic pain management program. The claimant was later placed at statutory maximum medical improvement with an 18% whole person impairment rating. Records indicate that on 08/20/12, the claimant was taken to surgery. Postoperatively, the claimant underwent a

course of surgical rehabilitation. On physical examination dated 11/20/12, the claimant has intact reflexes and no motor strength loss. She was opined to be at statutory MMI and received a 23% whole person impairment rating. The claimant was reported to have marked comorbid psychiatric conditions and a subsequent recommendation for individual psychotherapy.

The initial review was performed on 11/06/12 who noted that the treatment to date included a work hardening program and individual psychotherapy times four and chronic pain management program times 10 days and that the claimant was status post a C6-7 fusion on 08/02/12 and it was noted that her BDI was 21 and BAI was 5 and MMPI produced a valid protocol. found that the request for continued individual psychotherapy was not medically necessary and noted that the given that the claimant underwent work hardening program, chronic pain management program, and individual psychotherapy without sustained results that the claimant was unlikely to improve significantly with an additional psychotherapy.

The appeal request was reviewed on 11/28/12 who noted that the claimant may be a candidate for psychotropic medications based on the clinical data contained in the clinical record. He noted that she previously underwent psychological counseling and failed to respond to favorably. She was noted to remain off work. It was noted that she had multifocal complaints of pain, sleep disturbing, sleep disturbance, and depression. He noted that continued pursuit of a previously tried and failed treatment modality was both inadvisable and incompatible with current Official Disability Guidelines criteria and subsequently non-certified the request.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The submitted clinical records indicate that the claimant has a history of chronic cervical and shoulder pain as a result of a work place event. She has undergone extensive conservative management and ultimately underwent a single level ACDF. Post-operatively, the claimant has continued complaints of pain and her treatment has included work conditioning program and chronic pain management program. Records indicate that the claimant has not made any substantive benefit with the prior treatments and further the data suggests that she may benefit from psychotropic medications. Given that this modality has been previously attempted through individual psychotherapy as well as being components of both a work hardening program and chronic pain management program, there is no data to suggest that the claimant would receive benefit from additional sessions. Therefore it is the opinion of the reviewer that the request for 90806 Psytx Off 45-50 Min, 99212 Office Outpatient Visit Est, 99220 Initial Observation Care cannot be supported as medically necessary.

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)