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Notice of Independent Review Decision

July 1, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Individual Psychotherapy x 6 sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a licensed psychologist with over 25 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

01/16/2014: Encounter Summary
01/16/2014: X-Ray, Left Shoulder
Xx/xx/xx: Employers First Report of Injury or Illness
02/19/2014: Office Visit
02/27/2014: MRI, Left Shoulder
03/05/2014: Office Visit
03/11/2014: Office Note
04/09/2014: Mental Health Evaluation/Treatment Request
04/21/2014: Initial Diagnostic Screening
04/29/2014: UR
05/01/2014: History and Physical
05/09/2014: Response to Denial Letter
05/19/2014: MR Arthrogram Shoulder
05/21/2014: UR
05/30/2014: Disability Determination letter

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He notes that he felt a sharp pain, a stinging in his shoulder and in the back of the shoulder.

01/16/2014: Encounter Summary. **Chief Complaint:** Shoulder Pain **Problems:** Sprain of shoulder, shoulder pain **Assessment/Plan:** 1. Shoulder Pain 719.41 Pain in joint; pain in joint, shoulder region, Shoulder pain; after your visit, X-Ray, shoulder-Priority;STAT, drug screen-priority, STAT 2.Sprain of shoulder 840.9: Sprains and strains of unspecified sit of shoulder and upper arm. Discussion: Normal X-Rays, normal shoulder ligament exam. Pt with mild shoulder sprain, pt to take over the counter ibuprofen as needed.

01/16/2014: X-Ray, Left Shoulder. **Findings:** The glenohumeral joint is preserved. The acromioclavicular joint is within normal limits. The clavicle and ribs are unremarkable. **Impression:** Unremarkable shoulder exam.

02/19/2014: Office Visit. **Examination:** Pt is well nourished and cognitive and oriented x 3. He has a normocephalic expression. Cranial nerves 2-12 are intact. He has a negative Romberg and negative Babinski. Examination of the left shoulder shows minimal restriction in ROM though there are altered body mechanics with abduction and flexion. He has pain at extreme ROM with flexion and abduction. There is point tenderness over the supraspinatus tendon and the biceps tendon. There is some crepitus noted with internal and external rotation. There is point tenderness over the AC joint. Reflexes for the upper extremities are maintained at +2/+4. Strength in general is a 5/5 except for deltoid which is a 4+/5, reduced secondary to pain. **Clinical Impression:** Left Shoulder sprain-strain rule out internal derangement. **Treatment Plan:** 1. The patient will follow up in two weeks. 2. He will maintain his normal work status throughout this time period. 3. Physical therapy will be authorized for this patient. 4. The patient will be referred for determination regarding medication management and possible injection. 5. An MRI will be ordered for the left shoulder.

02/27/2014: MRI, Left Shoulder. **Impression:** 1. Mild interstitial tearing of the anterior supraspinatus tendon and the intra-articular segment of the biceps tendon. 2. Questionable posterior labral tearing versus prominent chondral labral junction. 3. Acromioclavicular joint osteoarthritis.

03/05/2014: Office Visit. **Subjective:** The patient presents today for follow up examination regarding injury sustained to his compensable body part, which is the left lower shoulder. Once again the patient does not feel like his left shoulder is getting exceptionally better; even getting worse. He does find that there is some minimal crepitus and popping, particularly with external rotation, abduction and flexion. There is point tenderness to the musculature. There is difficulty sleeping on the left side. **Examination:** Blood pressure is 122/80, pulse 72 per minute. Examination of the left shoulder today shows no significant changes in his overall physical parameters. In review of his orthopedic, neurologic, ROM, palpatory findings show no exceptional changes. **Plan:** 1. Follow up in 30 days 2. Maintain

normal work status throughout this time period. 3. Preauthorization for physical therapy will be requested to the ODG 4. Patient will be referred for assessment for medication management, review of the MRI and rule out injection therapy.

04/21/2014: Initial Diagnostic Screening. **Presenting Problem:** The patient is a male with a chief complaint of anxiety, stress, depression, pain, sleep problems, vocational concerns, psychosocial stressors, and physical limitations. was referred for initial/limited diagnostic screening for limited/inadequate treatment responsiveness, agitation, sleep disturbances, and return to work impairments. The recommendations are based on the psychological/emotional aspects of the injury, the treatment history, response to treatment, and psychosocial stressors that may be hindering expected recovery. **Psychosocial/Functioning (Present/Since DOI):** understands that he is inactive and cannot do any physical exercise. He feels he has weakened and gained significant weight recently. He believes that his medical/physical injury problem is extreme/severe and also believes that his injury problems/symptoms are extremely permanent. **Mental Health:** General Health/Lifestyle: Patient denies consuming any amounts of alcohol or caffeine. He noted no change in his diet but did note a 10-15 lb. weight gain due to lack of exercise combined with him not working. He reports his lifestyle as very inactive since the DOI. Family/Relationship: noted an increase in arguing/disagreeing in regard to finances and the relationship since his injury. He also noted a decrease in the activities him and his spouse shared since the injury. He otherwise indicated his wife as being warm, happy, enjoyable, understanding, and caring most of the time. Academic: Patient indicated he would like to return to school but sees his injury related physical limitations as health obstacles to returning to work. Occupational: Pt feels his employer has shown a lack of support, respect, and understanding in regard to his injury and his return to work. He indicated he will not be able to return to work because the company is experiencing issues. Financial: Since the DOI, indicated his financial status as extremely strained. He and his wife are living off their savings. He is attending school at this time. **Mental Status/Behavioral Observations:** Results of mental status examination revealed an individual who was alert and responsive to interview questions. Patient was casually dressed and groomed. Orientation was intact for person, time and place. Eye contact was appropriate. Speech functions were slowed for rate, volume, prosody, and fluency, with no evidence of paraphasic errors. Vocabulary and grammar skills were suggestive of intellectual functioning within the average range to below average range. The patient's attitude was open and cooperative. Affect was appropriate to verbal content and showed constricted range. Memory functions were grossly intact with respect to immediate and remote recall of events and factual information. His thought process was intact, goal oriented, and well organized. Thought content revealed no evidence of delusions, paranoia, or suicidal/homicidal ideation. There was no evidence of perceptual disorder. His level of personal insight appeared to be fair, as evidenced by ability to state his current diagnosis and by ability to identify specific stressors with precipitated the current exacerbation. Professional clinical observation, interview and test results indicated to be in the average range of intelligence. No serious primary neurological or physical impairment appears evident. **Clinical Impressions:** On the patient pain drawing, rated his pain as

7/10 indicating sever-very severe pain. He noted this pain as aching throughout his entire left shoulder. On the Pain Experience Scale, scored 57.5 indicating a moderate pain experience. He noted feeling frustrated and worrying about family very often. He additionally noted often feeling depressed because of pain and wondering how long his pain will last. The McGill Pain Questionnaire indicated a mild-moderate pain problem with a score of 24. described his pain as hurting, stabbing, heavy, and exhausting. He further indicated often experiencing this pain with a discomforting severity. On the Disabilities of the Arm, Shoulder and Hand (DASH), score 33.6 disabled. He indicated having moderate difficulty placing an object on a shelf above him, doing garden work, and pushing a heavy door. He also indicated severe pain and weakness in the shoulder, arm and hand. According to the sleep Questionnaire, he scored 38 indicating a moderate-serious sleep problem. He expressed having trouble falling asleep, waking up during sleep, gasping for air during sleep, and legs jerking during sleep. On the administration of the Beck Depression Inventory, he scored 11 indicating mild depression symptoms. He noted feelings of dissatisfaction, irritability, self-accusation, and self-dislike. According to the Beck Anxiety Inventory, he scored 14. He noted moderately being unable to relax, feeling terrified, and nervous. On the Fear Avoidance Beliefs Questionnaire, he scored 14 on the physical subscale and scored 34 on the work subscale. He expressed his pain was caused by his work or an accident at work and he cannot do physical activities that might make his pain worse. He additionally expressed he has a claim for compensation for his pain and his work is too heavy for him. **Diagnostic Impression:** Axis I- 309.9 Adjustment Disorder, unspecified, V62.2 Occupational Problems Axis II- 799.9 Diagnosis Deferred Axis III- 840.9 Shoulder Sprain Psychosocial Stressors (PSS) Related to injury (severity) 3-4, Moderate to Severe Axis V- Global Assessment of Functioning (GAF) Current: 58, overall serious Global Assessment of Functioning (GAF) Prior to Injury: 70 Mild Symptoms **Treatment Plan Recommendations:** Follow-up limited diagnostic mental health evaluation to monitor symptom progress and the patient's responsiveness to treatment planned and requested will be provided as part of Esequiel's 90806 Individual Psychotherapy. Mental Health Treatment: 90837 Individual Psychotherapy x 6. Once per every other week.

04/29/2014: UR. Rational for Denial: I spoke with LPC on 4/29/14 at 9:32AM CT. She stated that the claimant was not working. However, the clinical note documented "normal work status". stated that she would try to get clarification. As of the time of this submission, no additional information had been received. Recommend adverse determination. The claimant's psychometric testing was minimally elevated. There is some question as to the claimant's functional status. notes indicate return to normal work activities but there is report that the claimant has not worked since the DOI. It is unclear that the request meets ODG criteria for behavioral therapy. This review results in the following determination regarding the treatment being requested: Adverse determination.

05/01/2014: History and Physical. **History of Present Illness:** The patient states that he has been taking ibuprofen 200 mg one time per day without relief. He has had physical therapy, 9 sessions, which have helped some. He continues to have

anterior and lateral pain in the shoulder. The patient states that he has had one injection in his left shoulder. He describes a subacromial injection. He states that he had significant improvement from this for approximately 2 weeks, the pain has slowly returned but is not yet at baseline. His injection is noted to have occurred in March of this year. He denies previous left shoulder injury. The patient states that this injury is impacting him at home causing some difficulty to participate in normal household chores and maintenance. It is impacting him at work as he is not able to go back to work at less than 100% of his expected capacity. **Subjective:** The patient is complaining of left shoulder pain which is reported today at 5/10. This radiates along the left trapezial muscle into the left superior medial scapular border. He states it is made worse with muscle tightening such as shrugging of his shoulders and also pulling or pushing. It is made generally by relaxing. He denies numbness or spasm. **Assessment:** 1. Internal derangement of left shoulder. 2. Concern for left shoulder labral tear. 3. Left shoulder impingement. 4. Left shoulder sprain-strain. **Plan:** 1. Given the patient's equivocal clinical and imaging findings for labral tear, I will order an MR arthrogram of the left shoulder 2. Begin ibuprofen 800 mg 1 p.o. q 8h x 30 days 3. Continue physical therapy 4. Return to clinic post studies.

05/16/2014: UR. Rational for Denial: The claimant only had 4 sessions of physical therapy. Per ODG, CBT was designed to deal with pain states when traditional physical therapy had not proven useful. In addition, his therapist states that the therapy is vocationally aimed. Per ODG it should be aimed at a secondary depression which it does not appear the worker is actually evincing. For this reason, the appeal cannot be approved. Peer to peer contact was successful with no change in determination. This review results in the following determination regarding the treatment being requested: Adverse determination.

05/19/2014: MR Arthrogram Shoulder interpreted. **Impression:** 1. Mild infraspinatus insertional tendinosis and tiny partial thickness articular surface tear at its insertion. Negative for full thickness rotator cuff. 2. Mild AC joint osteoarthrosis.

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

The previous adverse determinations are upheld. I agree that clarification is needed on the claimant's current work status. Per ODG, initial therapy for "at risk" patients should be physical therapy using cognitive motivational approach to PT. If a lack of progress from PT alone, then separate psychotherapy CBT could be considered. According to the records, the claimant had only four sessions of physical therapy and no records indicating efficacy were provided. For these reasons, Individual Psychotherapy x 6 sessions is not medically necessary at this time and should be denied.

Per ODG:

ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:
Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ) in the Low Back Chapter.
Initial therapy for these "at risk" patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT.
Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:
- Initial trial of 3-4 psychotherapy visits over 2 weeks
- With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)
With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG Mental/Stress Chapter, repeated below.
ODG Psychotherapy Guidelines:
- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made.
(The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)
- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.
See Number of psychotherapy sessions for more information.

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)**