

Clear Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW:

8/14/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Four (4) weeks of individual psychotherapy, x 1 x per week

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

Licensed Master Social Worker, Licensed in Texas, Five (5) years experience in psychiatric hospital setting, on Adult Acute Care, Psychiatric Intensive Care, Chemical Dependency, and Children & Adolescent's Units; Assessments, Individual, Family, and Group Therapy.

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

Notification of case review (8/6/97)

Correspondence from Texas Dept. of Insurance

Letters of denial of services from (5/25/07, and 6/19/07)

Evaluation from systems (3/27/07)

Patient information, referral information, medical history, from DR. (3/27/07)

rehabilitative evaluations from Dr. (physical medicine & rehabilitation) (7/10/06 thru 11/21/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female high school art teacher who suffered a work-related injury on xx/xx/xx while working at in the. She reports going from standing to sitting beside a student when she missed the chair she was trying to sit down on, and fell to the floor. She struck her scalp behind her ear on some sort of surface, causing significant bleeding. She did not have any loss of consciousness, but did feel

disoriented. She did have neck pain as well. She worked one day after the injury. She is married and has five adult children. She lives with her husband.

After her injury, the patient complained of migraines, feeling unsteady, says her head feels “disconnected,” her eyes flicker and she loses the ability to focus, has vertigo and dizziness

She has had previous mental health treatments, and inpatient psychiatric treatment in 1999. She was diagnosed with depression. She reports possible head injury in her 20’s after which she felt some of the same symptoms, though they gradually subsided.

The patient has had several diagnostic tests, including X-Rays (xx/xx/xx) though nothing notable was found; mri x 2, first on left knee and then on brain; cat scan which showed chronic finding without acute intracranial event; and a panorex which showed a negative view of the mandible. She’s had individual counseling, reporting that it was “ok.” She also had neuro psychological testing, which showed rebound injury. Other than migraines, patient reports minimal pain.

Her psychological symptoms are sleep disturbance, trouble falling asleep and waking in middle of the night. Sleep has gone from eight hours per night to six, and 2—3 hours during the day. Patient shows depressive symptoms of loss of interest, fatigue, and loss of concentration. Beck anxiety inventory was 33—severe anxiety. Beck depression inventory was 25, indicating moderate depression. The LPC who evaluated the patient on 3-27-07 recommends that she enter an interdisciplinary chronic pain management program for four weeks, to cope with pain, stabilization of mood, and learn new coping skills.

Her DSm Iv Diagnostic impressions are:

Axis I	293.33 Major depressive disorder, recurrent, severe, without psychotic features
Axis II	no diagnosis
Axis III	920, 872.00, 847.0
Axis IV	Occupational problems
Axis V	Gaf (Current: 53) Highest past year (53) PRIOR to injury (80)

The patient’s referring physician is Dr. Dr. referred the patient to Dr. on 7/10/07. Her primary care doctor was Dr.. She also saw a psychiatrist, Dr. She saw a physical therapist, Dr., for evaluation, but did not follow up with recommendations for pt. She was enrolled in the Injury Transitional Services (BITS), during which she received psychotherapy. A neuro psychological evaluation was performed by Dr., PhD. She was seen by an ENT doctor, Dr..

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

According to the records, the neuro psychologist, Dr. indicated that the patient did have mild to moderate level of chronic depression and anxiety, but that the patient

had neuropsychological deficits that were not felt to be related to her depression and anxiety. He states the patient does have unequivocal findings of neuropsychological dysfunction. Dr. referred to Dr. formal summary, in which he listed:

1. Mildly impaired visual synthesis. He commented, "this is totally unexpected in an individual with her background unless there is specific involvement of the right side of the brain.
2. Working memory was impaired relative to the estimate of her premorbid function. This would mean she would have difficulty functioning adequately in busy, noisy environments and may have difficulty with multi-tasking.
3. Higher-level reasoning and problem solving is impaired. She would have difficulty understanding abstract information that she should have dealt with adequately in the past. She will most likely have difficulty synthesizing and analyzing new information. She would have difficulty making decisions about matters that are complicated or out of the ordinary.
4. mild impairment in the left upper extremity regarding finger dexterity and grip strength.

Dr. further stated that *these problems are of a sufficiently high level that they will probably not respond to cognitive therapy.* ("General Assumptions of Cognitive Therapy: Perception and experiencing in general are active processes that involve both inspective and introspective data. The patient's cognitions represent a synthesis of internal and external stimuli. How persons appraise a situation is generally evident in their cognitions [thoughts and visual images]. Those cognitions constitute their stream of consciousness or phenomenal field, which reflects their configuration of themselves, their world, their past and future. Alterations in the content of their underlying cognitive structures affect their affective state and behavioral pattern. Through psychological therapy, patients can become aware of their cognitive distortions. Correction of those faulty dysfunctional constructs can lead to clinical improvement." [, M.D. & , M.D. *Synopsis of Psychiatry*. Philadelphia; Lippincott Williams & Wilkens; 2003:956). Dr. suggested that time and stress management would be beneficial. Because velocity indicators on some of the tests indicate the picture was static, and the patient is already five months out from an injury that is in the mild, uncomplicated TBI range, this suggests that these deficits are permanent.

Dr. stated that she probably needs to resume psychological counseling and be in a supportive community setting to deal with her premorbid depression and anxiety issues as they are currently expressed. He stated that it was discussed with the patient that *this would need to be handled under her regular medical insurance since there is no indication on the neuropsychological assessment that this has changed due to her injury.*

Dr. reported that he would indicate that the patient has reached maximum medical improvement on 11/21/06. Her current medications are: Cymbalta, Wellbutrin, Ambien, Alprazolam, Flonase, over the counter antacid, Meclizine, Midrin, and Alieve. Dr. recommended an 8% impairment of the whole person. She is following up with a new counselor, , and will continue to see her psychiatrist.

At this time, based on available documentation of excellent care received in the past from many doctors who comprised a treatment team and communicated together regarding this patient, and because she can legitimately go to her medical insurance for this psychotherapy, this reviewer agrees with the recommendation of non-authorization of psychotherapy. The Reviewer considered the ODG Guidelines in the determination of the case, but as discussed above, the patient's circumstances were such that the Reviewer determined it was necessary to diverge from the guidelines.

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 (PLEASE SEE ABOVE)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)