

Applied Assessments LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 4/3/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Individual Psychotherapy 1 time a week for 6 weeks

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

M.D., Board Certified in Occupational Medicine in full-time 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)

Upon independent review the reviewer finds that the requested Outpatient Individual Psychotherapy one time a week for 6 weeks is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 12/31/07, 1/17/08
ODG Guidelines and Treatment Guidelines
Notice of Intent to Issue an Adverse Determination 12/28/07
Notice of Utilization Review Findings 1/17/08
Patient Information 11/6/07
Initial Behavioral Medicine Consultation 10/3/07

Work Related Injury Report
History and Physical 9/25/07
Follow-Up Visit Reports 12/26/07, 1/23/08, 2/20/08
Treatment Summary 10/31/07
Carrier Response 3/19/08
Notice of Utilization Review Findings 12/31/07, 5/11/07, 5/29/07, 5/30/07, 10/17/07,
11/29/07, 11/16/07, 11/30/07, 12/6/07, 12/14/07, 1/16/08
Maximum Medical Improvement Notice 1/2/08
Employee Report of Accident 10/25/06
Nurse's Report of Accident 10/25/06
Request To Change Treating Doctor 9/5/07
Report of Medical Evaluation 12/3/07
Review of Medical History and Physical Exam 12/20/07
MD Evaluation 9/20/07
Work Status Report 9/5/07, 10/26/06, 11/3/06, 3/22/07, 3/2/07, 4/23/07, 5/21/07,
8/14/07, 6/4/07
Follow-Up Report 10/30/07, 11/27/07
Individual Psychotherapy Notes 10/24/07, 10/19/07
Treatment Summary/Reassessment 10/31/07
Initial Evaluation 10/1/07
Assessment of Patient's Condition 10/15/07
Prescription Copy EMG/NCV
Lower Extremity Nerve Conduction 10/11/07
Electrodiagnostic Results 10/11/07
Assessment and Recommendation 11/5/07
Initial Behavioral Medical Evaluation 11/19/07
Behavioral Medical Service Reports 11/11/07, 1/7/08
Radiology Report 10/26/06
Work Injury Visits 11/3/06, 10/26/06, 3/27/07, 3/21/07, 3/2/07, 4/23/07, 5/21/07, 8/14/07,
6/4/07
Procedure Note 4/4/07
Report of Medical Evaluation 8/14/07
Injury Report xx/xx/xx
Lumbar Myelogram Notes 11/20/07
CT Lumbar Spine Post Myelogram 11/20/07
Progress Note 12/5/07
Physical Therapy Notes, 11/28/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient reported an injury to her lumbar spine, shoulder and leg on xx/xx/xx while employed as a classroom assistant. She has received block injections and physical therapy. She has had 6 sessions of cognitive behavioral therapy.

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

There is no indication in the materials available for review of improvement with the patient's initial cognitive behavioral therapy sessions. The ODG Guidelines from 2008 indicate that additional sessions of psychotherapy can be approved if improvement is

documented with the patient's initial sessions. Therefore, without specific documentation of improvement in the initial sessions, the requested Outpatient Individual Psychotherapy one time a week for six weeks is not deemed medically necessary.

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)