

# Clear Resolutions Inc.

An Independent Review Organization

7301 Ranch Rd 620 N, Suite 155-199

Austin, TX 78726

Fax: 512-519-7316

Notice of Independent Review Decision

**DATE OF REVIEW:** MARCH 6, 2008

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

6 sessions Individual Psychotherapy

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

MD, Board Certified in Physical Medicine and Rehabilitation

## **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**

Adverse Determination Letters, 1/2/08, 1/28/08

ODG Guidelines and Treatment Guidelines

DC, 2/7/08, 1/2/08, 11/27/07, 10/31/07, 1/3/07, 5/7/07, 4/2/07, 7/13/07, 10/8/07, 4/2/07, 6/15/07, 9/5/07

MD, 11/15/07, 12/4/07, 1/10/08, 2/7/08

LPC, 10/31/07, 12/20/07, 1/19/08

IRO Summary Letter from , 2/28/08

Hospital records, 6/13/04-6/14/04

Radiology Report, 6/13/04

MD, 6/18/04, 7/14/04, 8/4/04, 8/18/04, 9/8/04, 1/12/05

MRI of Lumbar Spine, 8/11/04  
MD, 9/2/04, 9/29/04  
MD, 6/15/07, 10/8/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a back injury in xx/xx when lifting a bag of fertilizer. She was seen in the local emergency room. An MRI that summer showed a left sided disc bulge at L4-5 without extrusion or nerve root compression. The associated findings of disc desiccation and disc space narrowing combined with the x-rays in the emergency room showing hypertrophic degenerative changes suggested a chronic condition. She had transient relief with epidural injections. Dr. advised back surgery, but no definite root compression was found. Surgery was not performed. She continued with back pain and burning leg pain. The examinations by Dr. showed reduced left knee jerk, positive straight leg raising and SI pain. Dr. advised a pain clinic. Dr. felt a disc replacement surgery should be considered. She was at a statutory MMI in 2006, but had not been assigned a rating per Dr.. She had not been able to perform much with an FCE. She was evaluated by for a pain/counseling session. She was reported to be depressed and had prior treatment for depression in 2001. She had weight gain from the depression. She has anxiety. She was found to have problem dealing with her negative emotions and she had issues with distorted beliefs of her back pain and disability.

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

The medical records that were reviewed suggest someone with a history of degenerative age related changes in her back aggravated by a strain. There may have been a disc injury, but there is no evidence of any radiculopathy from the reports. She is at statutory MMI. Six sessions of individual counseling were requested by, LPC after Dr. advised a chronic pain clinic, which has been denied on two occasions. Mr. felt that this patient would be able to return to work after being off work for 4 years. The patient described appears to have poor insight and remains quite depressed. The description of the findings and the MRI did not appear to justify any surgical intervention. She appears to be in the DRE category I with the nonspecific nondermatomal symptoms and none of the objective evidence of a radiculopathy. The reviewer is concerned that the patient's symptoms do not identify any specific nerve root and her long term perception of a severe problem will limit the benefits of any psychological counseling sessions. The reviewer therefore will uphold the previous adverse determination and find that 6 sessions of individual psychotherapy are not 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)