



Notice of Independent Review Decision

DATE OF REVIEW: 07/23/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cognitive Behavioral Therapy Two Times Per Week for 90 Days
Medical Biofeedback Two Times Per Week for 90 Days

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

Board Certified in Forensic Psychiatry
Board Certified in Addiction Psychiatry
Board Certified in Pain Medicine

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 or not medical necessity exists for each of the health care services in dispute.

Cognitive Behavioral Therapy Two Times Per Week for 90 Days – Upheld
Medical Biofeedback Two Times Per Week for 90 Days – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Emergency Psychiatric Evaluation & Pre-Authorization Request, M.D., 03/25/04
- Psychiatric Component Impairment Rating, Dr. 07/28/04
- Specific & Subsequent Medical Report, Dr. 11/18/04, 03/01/05, 04/19/05, 06/30/05, 10/06/05, 12/13/05, 03/28/06, 08/0/06, 01/23/07, 04/26/07, 06/14/07, 10/16/07, 02/26/08, 06/09/08, 11/17/08, 11/24/08, 02/16/09, 05/26/09
- Independent Medical Examination, M.D., 12/11/06
- Pre-Authorization Request, Dr. 05/26/09,
- Denial Letter, 06/01/09, 06/18/09
- Reconsideration Request, Dr. 06/10/09, 06/16/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had fallen over boxes stacked outside the door of a drive-in facility injuring her left knee. She had two arthroscopic surgeries, in which she continued to have chronic pain. She underwent an emergency psychiatric evaluation, due to suicidal ideation in relation to the injury to her knee. She had undergone an impairment rating and was found to have reached statutory MMI on 04/23/04 with a psychiatric component impairment rating of 50%. An Independent Medical Evaluation (IME) was also performed on the patient. She was regularly treated by Dr. with her current medications being Nexium 40 mg, Celexa 60 mg, Sonata 10 mg and Invega 3 mg.

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

Cognitive behavior therapy and medical biofeedback are not medically reasonable and necessary.

The rationale is that the records reviewed indicate the patient has had over 100 individual psychotherapy and/or medical biofeedback sessions with this provider and there is no indication that there has been substantial improvement with the therapy. Additionally, the records reviewed indicate the patient has had previous chronic pain management. Also, the requests are excessive and not consistent with ODG Web-based guidelines, and the patient is not identified as an appropriate patient for continued intensive treatment as there is an absence of documentation of significant medical benefit.

The criteria used are ODG Web-based Guidelines for Cognitive Behavioral Therapy /Guidelines for Chronic Pain, which state “with evidence of objective functional improvement, a total of up to thirteen to twenty visits over thirteen to twenty weeks of individual sessions.” Additional ODG Web-based Guidelines for Biofeedback state “possibly consider biofeedback referral in conjunction with CBT after four weeks after an

initial trial of three to four psychotherapy sessions over two weeks with evidence of objective functional improvement, a total of up to six to ten visits over five to six weeks.”

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)