

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/15/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual Psychotherapy 1x/week x 4 weeks

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

MD, Certified by the American Board of Psychiatry and Neurology
Licensed by the Texas State Board of Medical Examiners

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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 4/2/09, 4/29/09
Dr. 3/18/99-4/27/09
Dr. 1/5/09
Dr. 2/4/09
Dr. 2/23/09
DC, 3/10/09
LPC, 3/10/09, 4/22/09
MRI, 4/17/97, 1/18/99, 10/30/08, 4/25/07
EMG/NCV, 5/8/97, 2/4/09
Lumbar Discogram, 3/20/98
Lumbar Myelogram, 1/5/09
Physical Therapy, 4/1/97-2/26/99
FCE, 3/10/09
Lumbar ESI, 5/16/97, 11/18/97
Facet injection, 8/4/07
Lumbar Fusion, 6/1/98

Transforaminal Lumbar ESI, 9/17/07, 6/30/08 MD, 6/2/05
Dr. 3/21/97
Dr. 4/17/97
Dr. 5/8/97
Dr. 5/16/97
Dr. 3/20/98,
Dr. DO, 5/12/98
Dr. 6/1/98
Dr. 6/1/98
Dr. 1/18/99
Dr. DO, 10/2/00
Dr. MD, 4/25/07
RN, 6/30/08
Dr. 6/30/08

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female injured on the job when she bent down . When she stood up, she felt low back pain. Her initial medical treatment was on xx/xx/xxxx. Her current diagnosis is lumbosacral neuritis, radiculitis, post laminectomy syndrome lumbar region. She had surgical procedures, physical therapy, repeat MRI scans and has taken the following medications: Neurontin, Elavil, Motrin, Darvocet and Amitriptyline. She has never had work hardening, work conditioning, chronic pain management or psychological intervention according to the records provided. On 3/9/2009 her orthopedic surgeon wrote: "most of her symptoms are related to that of a functional overlay."

On 3/16/2009, she was recommended for 10 sessions of a chronic pain management program to raise her physical demand level, teach her more effective methods of dealing with pain outside of the clinic and reduce her need for medication. However, this never took place. Psychological evaluation dated 3/10/2009 noted psychological symptoms including sleep disruption, fatigue and mild depression. BDI and BAI indicated mild anxiety and depression. Short term treatment goals were established as: reduce pain level, be more active, prepare for return to work. More extensive long term goals were also outlined. Four sessions of individual psychotherapy were requested to accomplish these modest goals, but were denied by the previous reviewers as not being medically necessary.

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

This patient was first injured at work. The patient has continued to have symptoms related to back pain. Providers have given multiple expensive evaluations and treatments with little relief. The reviewer believes it is reasonable at this point that psychological factors should be considered and dealt with. It is quite reasonable that dealing with evaluations, treatments and pain would take a considerable toll on a person psychologically. The fact that the patient shows only mild problems psychologically is a positive sign for a good prognosis with treatment. The request for psychological treatment for pain with these appropriate goals and hope for progress meets the ODG criteria for psychological treatment. The reviewer finds that medical necessity exists for Individual Psychotherapy 1x/week x 4 weeks.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)