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**Notice of Independent Review Decision  
Notice of Independent Medical Review Decision  
Reviewer's Report**

**DATE OF REVIEW:** August 13, 2010

**IRO CASE #:**

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

A female patient has requested coverage for individual psychotherapy, once a week for six weeks.

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

M.D., Board Certified in Psychiatry

**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)

I have determined that the requested individual psychotherapy, once a week for six weeks, is medically necessary for treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 7/22/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Medical Review Organization (IRO) dated 7/23/10.
3. TDI Notice of Assignment of Independent Review Organization dated 7/26/10.
4. TDI Notice to IRO of Case Assignment dated 7/16/10.
5. History and Physical dated 5/24/10.
6. Initial Behavioral Medicine Consultation dated 5/26/10.
7. MRI report dated 6/15/10.
8. Denial documentation.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work related injury to her left upper extremity, left rib, and low back on xx/xx/xx while performing her customary duties. She walked out of the cooler carrying three boxes of strawberries to the sink and slipped on a cardboard box that was lying on the floor. She fell forward, striking a table, causing a merchandise pallet weighing approximately

100 pounds to fall on top of her. Her medical diagnoses are thoracic, lumbar and left shoulder sprain/strain; left knee internal derangement; and nerve root irritation with paresthesias to the left foot. The patient has received conservative treatment, lifting restrictions, Relafen and Darvocet. She is currently working two days a week. She has participated in six sessions of physical therapy without reports of benefit.

The patient underwent a psychological evaluation on 5/26/10 after completing physical therapy. She endorsed symptoms of irritability, frustration and anger, tension, anxiety, sadness and depression, and sleep disturbance. She scored 24 on the BDI-II (moderate depression), 18 on BAI (moderate anxiety) and significant fear avoidance of physical activity in general on the FABQ. A request has been made for six sessions of individual psychotherapy (cognitive behavioral therapy (CBT)) to control reactions involved in the pain experience, improve the patient's sleep hygiene, increase engagement in activities and performance of chores at home, and support the patient in continuing to work for her current employer. The Carrier denied the request, citing a lack of medical necessity.

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

The medical records provided support the request for approval of six sessions of individual psychotherapy (CBT) sessions for this patient. Official Disability Guidelines (ODG) specifically instruct that clinicians screen patients with low back problems for risk factors for delayed recovery, including fear avoidance beliefs. Per ODG guidelines, initial therapy for at risk patients should consist of physical therapy exercise instruction, using a cognitive motivational approach to physical therapy. ODG guidelines recommend consideration of separate cognitive behavioral therapy (CBT) referral after four weeks for patients who have experienced lack of progress with physical therapy alone.

A review of the record indicates that the patient fulfills the ODG criteria for CBT. She has low back pain, has received initial physical therapy without benefit, and has been screened and found to have fear avoidance factors, which are likely to lead to a delayed recovery. The referral for CBT to deal with this issue is consistent with applicable guidelines in this setting. Of additional note, pain disorder is a DSM-IV recognized diagnosis and CBT is considered an appropriate modality for treatment of patients with chronic pain. Furthermore, this patient's behavioral evaluation documented the presence of depression and anxiety as well as pain. Thus, the requested six sessions of individual psychotherapy (CBT) are medically necessary for treatment of the patient's medical condition.

**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)