

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/13/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual psychotherapy 1 x 6

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

MD, Psychiatrist

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, Pain
Adverse Determination Letters, 6/23/10, 7/22/10
Injury 1, 7/19/10, 6/17/10
Texas Health, 12/7/09

PATIENT CLINICAL HISTORY SUMMARY

The patient is a woman who suffered a work related injury on xx/xx/xx. She was injured as the result of a motor vehicle accident, and suffered an injury to the neck and back. Current medications include amitriptyline, Flexeril and Lortab. The psychological evaluation on 12/07/2009 indicated that the patient was experiencing severe depressive symptoms and moderate symptoms of anxiety. Diagnostic impressions included MDD. A course of physical therapy was completed, and the patient is reportedly engaged in a home exercise program. The patient continued to work, part time, post injury but was subsequently fired from her position. ADL's are unimpaired at this time, except for extended driving tolerance. The patient has now completed 13 sessions of individual psychotherapy. A brief treatment update on 06/17/2010 provides only a small amount of information. The scales actually note that the patient has increased symptoms in the areas of pain, depression and anxiety after treatment compared with pre-treatment. The therapist notes that the patient had run out of her medications prior to the reassessment, and opines that this is the reason for the increase in symptoms. The insurance company reviewer has denied the request for 6 additional sessions of psychotherapy with the following rationale: "ODG state that the additional psychological treatments should only be provided with evidence of objective functional improvement from previous psychological treatments." "A brief treatment update on 6/07/2010 provided minimal data concerning the patient's response to these sessions, no objective functional improvement is reported and psychological symptoms have increased."

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

A review of the records in this case does confirm the opinion of the insurance reviewer. There is only one note re-evaluating the patient after 13 sessions of treatment, and it shows that her depression, anxiety and pain have increased. The therapist opines this is due to the patient not receiving her medications prior to the re-evaluation. If this is correct, it implies that the psychotherapy has not been beneficial, but rather, only the medications have been helpful. Thus, the insurance company reviewer's opinion that the treatment is not showing functional improvement is correct, and by ODG standards, further individual psychotherapy treatments are not medically necessary. The reviewer finds that medical necessity does not exist for Individual psychotherapy 1 x 6 as the guidelines have not been satisfied and no explanation has been provided as to why the guidelines should not be applied in this case.

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)