

US Resolutions Inc.

An Independent Review Organization
1115 Weeping Willow
Rockport, TX 78382
Phone: (512) 782-4560
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Individual Counseling 1 x wk x 6 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

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

Adverse Determination Letters, 5/25/10, 6/22/10

Rehab 2/23/10

Health Care Systems 5/17/10, 6/15/09, 6/8/10

Healthcare Systems 6/12/09

Chronic Pain Management Program 1/26/10 to 4/9/10

BHI 2 -- 1/29/10

M.D., 5/20/10, 6/8/10

PATIENT CLINICAL HISTORY SUMMARY

This patient was injured on the job on xx/xx/xx when she slipped and fell on a wet floor. She began to fall backwards but immediately turned and grabbed the edge of the wall, experiencing immediate pain. She has had care including 20 sessions of a chronic pain management program. She also reports a 40-year history of psychiatric treatment, including a one-week hospitalization in 1973. The patient takes pain medications and Effexor XR 150 mg. for depression. She continues to be unemployed and to experience pain on standing and sitting. A request was made for six sessions of individual counseling. The insurance company reviewers stated that it is not medically necessary and denied the request. They cite the fact that there is no objective evidence that the patient has improved with previous psychological treatments. They do not feel that this particular candidate is an appropriate patient for further psychological treatments given the chronicity of her problems. Additionally, they cite the fact that her diagnosis is chronic pain syndrome and that there is no known effective psychotherapeutic treatment for such disorders. . The record contains an RME by Dr. dated May 20, 2010. He concludes that no further psychological intervention would be helpful at this point.

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

The reviewer agrees with the determinations of the prior reviewers based upon the medical records submitted. Records indicate this patient has chronic pain syndrome despite multiple treatments, both physical and psychological. She is already receiving long-term psychiatric

care and anti-depressant medication and additionally has completed a 20-session pain management program. It is unclear to this reviewer what more could be gained from 6 individual counseling sessions. The request does not conform to the ODG criteria. The reviewer finds that medical necessity does not exist for Individual Counseling 1 x wk x 6 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)