

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/06/2010

**IRO CASE #:**

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

4 sessions individual psychotherapy

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

MD, Psychiatrist

Board 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**

11/4/10, 10/26/10

P.C. 11/11/10, 10/20/10

Diagnostics 4/28/10

Evaluations 6/10/10, 6/8/10

Pain

Cognitive Behavioral Therapy

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a man who was injured on xx/xx/xx at work when he tried to roll an extremely heavy object and felt an immediate pain in his back. Notes indicate he most likely suffered an acute disc herniation with back pain and pain in his right leg. Treatment has included conservative care, bilateral foraminotomies, cervical fusion and lumbar decompression and fusion in mid 2010. He has had 14 previous sessions of psychotherapy, which were reported to have been very successful in alleviating pain, helping him lose weight and reduce his pain medications. After his most recent surgery, he was again referred to P.T. However, he apparently was unable to tolerate the pain and quit the treatment prematurely. A request was made for 4 sessions of psychotherapy. This was denied, with the rationale that he was progressing successfully in his P.T. program, and thus the psychotherapy was not indicated.

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

The rebuttal letter dated November 11, 2010 indicates that the P.T. has been unsuccessful because of psychological factors including fear avoidance. Apparently this information was not available to the insurance reviewer. However, given the patient's previous favorable response to psychotherapy prior to his most recent surgery, additional psychotherapy would be consistent with ODG, which suggests therapy if P.T. is not progressing after several weeks. The reviewer finds that medical necessity exists for 4 sessions individual psychotherapy. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

**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)