

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/11/2010

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

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

Adverse Determination Letters, 12/14/09, 1/15/10
Injury 1, 12/10/09, 1/5/10, 11/16/09, 10/1/09
Official Disability Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

THE PATIENT IS A MALE WITH A DATE OF INJURY OF xx/xx/xx. THERE IS A HISTORY OF NECK AND LOW BACK PAIN COMPLAINTS, FOLLOWING REPORTED MVA. TRETMENT HAS INCLUDED CONSERVATIVE CARE, INJECTIONS, PSYCHOTHERAPY, SURGERY, 20 DAYS OF WORK HARDENING, AND 4 DAYS IN A CHRONIC PAIN MANAGEMENT PROGRAM IN 2003. A SPINAL CORD STIMULATOR WAS REMOVED IN 2007. THE PATIENT CURRENTLY WEARS A SHORT LEG BRACE ASSOCIATED WITH HIS FOOT DROP. THE PATIENT HAS COMPLAINED OF VERTIGO POST INJURY. CURRENT MEDICATIONS ARE MECLIZINE AND MIDRIN. A REQUEST HAS BEEN MADE FOR 4 SESSIONS OF INDIVIDUAL PSYCHOTHERAPY. RECORDS SHOW EVIDENCE OF A PAIN DISORDER AND MILD DEPRESSION.

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

THIS PATIENT IS xx YEARS OUT FROM HIS DATE OF INJURY. RECORDS SHOW EVIDENCE OF A PAIN DISORDER AND MILD DEPRESSION. HE HAS HAD MULTIPLE INTERVENTIONS, INCLUDING 2 SURGICAL PROCEDURES, INDIVIDUAL PSYCHOTHERAPY, PAIN MANAGEMENT PROGRAM AND 20 DAYS IN A WORK HARDENING PROGRAM. THIS REVIEWER AGREES WITH THE PREVIOUS REVIEWER THAT FOUR SESSIONS OF PSYCHOTHERAPY ARE NOT MEDICALLY NECESSARY FOR THIS PATIENT. THE REVIEWER AGREES WITH THE PRIOR REVIEWER THAT THIS IS NOT AN "APPROPRIATELY IDENTIFIED PATIENT," AS IS REQUIRED BY THE ODG. THE REVIEWER AGREES WITH THE PRIOR REVIEWER THAT SEVERAL SESSIONS OF INDIVIDUAL PSYCHOTHERAPY HAVE BEEN PROVIDED AND THAT

THERE IS NO EVIDENCE OF THE PATIENT'S RESPONSE TO THE SESSIONS. THE ODG STATES THAT ADDITIONAL PSYCHOLOGICAL TREATMENT SHOULD BE PROVIDED IN CASES WHERE THERE IS EVIDENCE OF FUNCTIONAL IMPROVEMENT FROM PREVIOUS SESSIONS. THIS EVIDENCE HAS NOT BEEN PROVIDED IN THE RECORDS. THE REVIEWER FINDS THAT MEDICAL NECESSITY DOES NOT EXIST 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)