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Notice of Independent Review Decision

**DATE OF REVIEW:** July 11, 2010

**IRO CASE #:**

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

Individual psychotherapy, once a week for six weeks. Lumbar. CPT codes: 90804, 90806 and 90808.

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

GENERAL AND FORENSIC 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**

TRANSCRIPTION WILL LIST MEDICAL RECORDS HERE WITH SPECIFIC DATES

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- Ph.D., 03/19/10
- 06/08/10, 06/18/10
- L.L.C., 06/11/10
- D.C., 06/11/10
- Texas Department of Insurance, 06/24/10

Medical records from the Provider include:

- M.D., 03/12/10
- Ph.D., 03/19/10, 07/06/10

**PATIENT CLINICAL HISTORY:**

The patient was injured in a motor vehicle accident, injuring his low back, right arm, and left knee. He has received multiple diagnostic evaluations and procedures including MRI and physical therapy; however, he continues to have severe pain and has not returned to work. Initial psychological evaluation indicates some avoidant behaviors and psychological barriers to making progress. Measures to assess depression and anxiety indicate moderate depression and anxiety complaints. The patient was diagnosed with a chronic pain disorder associated with psychological factors and a general medical condition. There is a proposal for six sessions of individual therapy to help reduce the depression and anxiety symptoms and address psychological issues that are hindering rehabilitation.

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

**ODG cognitive behavioral therapy (CBT) guidelines for low back problems:**

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See [Fear-avoidance beliefs questionnaire \(FABQ\)](#).

Initial therapy for these “at risk” patients should be [physical therapy exercise](#) instruction, using a cognitive motivational approach to PT.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks

- With evidence of objective [functional improvement](#), total of up to 6-10 visits over 5-6 weeks (individual sessions)

The requested trial of cognitive behavioral therapy is reasonable. The patient has failed to progress with physical therapy and conservative measures, and based on the evaluation, there are psychological barriers to his progress. While I agree with the carrier’s reviewers that prognosis is guarded and ACOEM guidelines would argue for consideration of a multidisciplinary chronic pain program over a more unimodal approach at this point in his treatment. The ODG supports a trial of CBT of 4 visits over 2 weeks. The carrier’s reviewers also appropriately point out that continued therapy beyond the initial trial will require the provider to show objective evidence of functional improvement.

**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)