

SENT VIA EMAIL OR FAX ON  
May/11/2010

## Applied Assessments LLC

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/10/2010

**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:**

Board certified in Physical Medicine and Rehabilitation. Medical Director of Rehabilitation

**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**

OD Guidelines

Denial Letters 4/16/10 and 4/12/10

Dr. 4/6/09 thru 1/7/10

Pain Care 3/8/10 thru 4/9/10

Range of Motion 4/6/09

**PATIENT CLINICAL HISTORY SUMMARY**

This worker was lifting a pipe without assistance when he felt pain in the low back. He did receive treatment. He was working light duty. He went on vacation and returned one day later than scheduled. He was terminated. He then sought legal counsel. He has 45 degrees flexion of the spine. He has right EHL weakness. Otherwise good lower extremity strength. There is L5S1 spondylolisthesis. The PT gave transient relief. ESI gave relief for 24 to 48 hours. Patient is afraid that returning to work will make the back pain worse. He has considered surgery. He has moderate anxiety and depression by self-report.

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

Psychological evaluations are indicated and recommended to determine a clinical impression of psychological conditions that impact recovery. There are 26 Psychological tests commonly used in the assessment of chronic pain patients. These tests were not used for this patient. Therefore there is not enough information to determine the necessity of psychological treatment times 6. The notes provided do not show that goals are set or that appropriateness of treatment has been established.

**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)