

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Mar/29/2011

**IRO CASE #:**

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

Individual Psychotherapy x 6 visits at 1 time a week for 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**

Official Disability Guidelines

Clinic 2/15/XX, 3/3/XX

Clinic 2/8/XX to 3/14/XX

M.D. 1/26/XX to 2/23/XX

Ph.D., ABPP 3/2/XX

Ph.D. 2/15/XX

**PATIENT CLINICAL HISTORY SUMMARY**

The patient had an injury to her shoulder on XX/XX/XXXX . She has received diagnostics, PT and medications. She is taking ibuprofen. She rates her pain as 6/10 and has a BDI of 10 and ABI of 8. She does report fear-avoidance issues. She has reportedly been working full time with restrictions. A request was tendered for 6 sessions of IT. This was denied. The first reviewer stated that since she is already working, it was unclear as to how the treatment team planned to address her fear avoidance issues. The second reviewer stated that patient is working full time with restrictions, taking no prescribed pain medication, has low psychological distress scores and thus there is no evidence that psychological factors are impairing her functional ability.

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

The treatment team has provided weak evidence that this patient is suffering significant psychological problems that would prevent her from being able to work. Thus, this is not an appropriately identified patient for psychological treatment for chronic pain according to the

Official Disability Guidelines. The reviewer finds there is not a medical necessity for Individual Psychotherapy x 6 visits at 1 time a week for 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)