

Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual Psychotherapy 6 sessions over 8 wks

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

MD, Psychiatrist, 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 – CBT Guidelines

6/14/11, 7/8/11

5/16/11-6/27/11

Bone and Joint Clinic 8/16/04 - 4/26/11

Diagnostic Imaging 1/15/08

PATIENT CLINICAL HISTORY SUMMARY

The patient is a man with a DOI of xx/xx/xx. The injury is described as being caused by throwing a spare tire in the back of a truck. Treatment has consisted of conservative care, ESI's and lumbar rhizotomies. The patient is reported to be working full time in HVAC as a supervisor. He continues to have back pain with an occasional radiation down the right posterior leg. His pain levels are generally very low in the morning, 2/10, but can increase as high as 8 or 9 by noon or 1 PM. Aggravating factors include working, lifting, bending and stooping. He uses diclofenac once daily for pain control and Motrin prn. He has had recommendations for decompression and stabilization of the L4, L5 and S1; however, he is wishing to put this off as long as possible. His physician stated that he is recommending multidisciplinary approach and adds: "We will follow him as long as he wishes and when he is ready to have a decompression and stabilization Dr. will be happy to accommodate him." A request was made for 6 sessions of psychotherapy with the rationale being that the patient has signs of depression and anxiety and sleep disturbance. The request was denied stating that this is not an appropriately identified patient. The reviewer feels the instruments were inadequate to provide relevant diagnostic information. A rebuttal was included in the record states: "Initial request will be for individual psychotherapy to determine his candidacy for interdisciplinary care in the future as he is at tertiary care."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The treating psychologist indicates that the reason for the request for these sessions is to determine the patient's candidacy for interdisciplinary care in the future. ODG is clear that a requirement for this type of care is a thorough psychological evaluation with specific testing instruments. ODG makes no mention of response to 6 sessions of psychotherapy as criteria for CPMP or other programs. The guidelines have not been satisfied. There is no medical necessity for Individual Psychotherapy 6 sessions over 8 wks. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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)