

SENT VIA EMAIL OR FAX ON
Feb/04/2011

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

6 sessions of individual psychotherapy

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

Certified by the American Board of Psychiatry and Neurology with additional qualifications in Child and Adolescent Psychiatry

Licensed by the Texas State Board of Medical Examiners

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

12/17/10 thru 1/11/10

OP Reports 8/24/09 and 2/22/10

MRI 12/7/10

1/4/11 and 1/19/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female who was injured at work on xx/xx/xx. She was working as a that manufactures screws. She was with an industrial hammer when she felt immediate pain in the right shoulder. She underwent PT and had two surgical procedures on 08/13/2009 and February 2010 without relief. She also had one ESI injection following her second surgery without improvement. She currently receives Tramadol, ibuprophen, Orphenadrine and

amitriptyline. She received an initial mental health evaluation on 12/28/2010. She presented with a flat, sad affect with congruent mood and felt depressed over her loss of independence and inability to work. She had high scores on the BDI and BAI and was given a diagnosis of Pain disorder associated with both a psychological and a general medical condition. A request was made for 6 sessions of individual psychotherapy. This request was denied both initially and upon appeal as not being an appropriately identified patient. The second reviewer cited ODG. "There is no quality evidence to support the independent/unimodal provision of CBT for treatment of patients with chronic pain syndrome." "Screen patients with risk factors for delayed recovery, including fear avoidance beliefs. Initial therapy for these 'at risk' patients should be PT. Consider separate CBT referral after 4 weeks if lack of progress from PT alone." CBT for depression or anxiety is only appropriate when it is the primary focus of treatment, which is not the case with this patient who is reporting chronic pain. The treating provider then wrote an appeal letter. He stated that this patient is depressed and that the BDI and BAI, which support this, are approved under ODG. Furthermore, he contradicts the reviewer's characterization of the patient's diagnosis as a chronic benign pain syndrome. Finally, he defends the therapy goals in the patient's treatment plan as being specific and targeting relevant symptoms.

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

ODG states: "Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and PTSD). CBT and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work." Given these guidelines, then, the request for 6 sessions of IT in this patient are reasonable and within ODG and should be approved.

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 KNOWLEDGBASE

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)