

# US Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jul/09/2011

**IRO CASE #:**

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

Individual Psychotherapy 1x4 weeks

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

MD, Board Certified Psychiatrist  
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 and Treatment Guidelines  
5/17/11, 6/14/11  
3/11/11 to 6/6/11  
12/15/10

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a man who was injured while performing his customary duties as a xx . On xx/xx/xx his right thumb was caught and smashed. He has been treated with physical therapy, surgery and a work hardening program, which he was unable to complete. He underwent a behavioral medicine evaluation on 05/03/2011. He was noted to show fear of reinjuring his thumb, mild depression and severe anxiety, as assessed with the BDI and BAI, respectively. He has not been able to meet required work PDL and has not been released to return to work by his treating doctor. He also relates sensitivity to touch in his right thumb and unbearable pain, which radiates from his thumb up his forearm to the right side of his neck. He relates difficulty with personal care. A request was made for 4 sessions of individual psychotherapy. This request was denied initially and upon appeal. The appeal denial rationale was that this patient is not an appropriately identified patient for psychotherapy because he has a chronic pain disorder.

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

ODG Pain-psychological treatment recommends psychotherapy for pain patients. Among the reasons for intervention, ODG lists conceptualizing a patient's pain beliefs and coping styles and addressing co-morbid mood disorders such as depression, anxiety, etc. The behavioral medicine consultation for this patient indicates that he has significant fear avoidance, anxiety,

and coping problems, all of which make him an appropriate patient according to ODG. The reviewer finds that the previous adverse determination/adverse determinations should be overturned because there is a medical necessity for Individual Psychotherapy 1x4 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)