

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/03/2011

**IRO CASE #:**

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

Urine Drug Screen - 80101  
Group Psychotherapy Therapy 1 x Weekly x 12 weeks - 90853  
Biofeedback Therapy 2 x Weekly x 12 weeks - 90901  
Psychological Testing - 3 hours - 96101  
Cognitive Behavioral Therapy 2 x weekly x 12 weeks - 90806

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

MD, Psychiatrist  
Board 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)

The reviewer finds that Cognitive Behavioral Therapy 2 x weekly x 12 weeks – 90806 and Group Psychotherapy Therapy 1 x Weekly x 12 weeks – 90853 and Biofeedback Therapy 2 x Weekly x 12 weeks – 90901 are medically necessary.

The reviewer finds that Urine Drug Screen – 80101 and Psychological Testing - 3 hours – 96101 are not medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines  
Carrier, Adverse Determination Letters, 5/9/11, 5/13/11  
Information in Support of Patient's Request for IRO, Dr. 5/19/11  
Texas Administrative Code, Rule 19.2005, undated  
MD, Bio, undated  
MD, Bio, undated  
Medical Board, 5/16/11  
Letter to Dr., 11/19/99  
ODG-TWC, Appendix D, Documenting Exceptions to the Guidelines, Email Dated 3/9/11  
Request for Expedited Reconsideration for Imminent Services, Dr. 5/10/11  
Psychiatric Evaluation and Request for Preauthorization of Treatment, Dr. 4/12/11  
BDI-II, 4/12/11  
MCMII-II, 4/12/11  
MD, 4/25/11  
MD, Curriculum vitae  
Provider, handwritten notes, 1/3/11, 1/17/11

Report of Medical Evaluation, 3/7/11  
Designated Doctor Examination, 3/7/11  
Employee Request to Change Treating Doctor, 4/25/11  
Photographs, undated  
Dr., Operative Report, 11/5/10  
Note from Friend of Patient, 5/10/11

#### **PATIENT CLINICAL HISTORY SUMMARY**

The patient is a XX-year-old female who was working on XX/XX/XX when three men burst in to her place of business with automatic weapons, brandishing them and screaming. The men were dressed in black with masks and gloves. The patient was thrown to the floor and dragged by her hair with a gun to her back. One of the robbers threatened her life. The employees were forced to give the robbers their money and they departed. Subsequently, the patient has experienced increasingly severe symptoms of anxiety, depression, confusion and emotional isolation. She also complains of palpitations, shortness of breath, trembling, feelings of terror and panic, nervousness, insomnia, nightmares, sensitivity to noise, irritability, change in personality, detachment and suicidal ideation. On XX/XX/XXXX she had a MVA. While driving in her vehicle, several men in another vehicle attempted to speak to her and to get her attention and as they resembled the robbers, she had a panic attack and drove her car into a ditch resulting in severe injuries to her right elbow, including an ulnar fracture, severance of the ulnar nerve. Treatment included an open surgical reduction. She is no longer able to straighten her right arm and she has numbness of the fourth and fifth digits and has difficulties with driving and writing. She is terrified now of certain establishments and has avoidance of them. She has shown severe depression on the BDI. On the MCM-III she was noted to have a severe mental disorder. Some of the findings noted that she deals with her anxiety and mistrust of others by muting her feelings. She may experience considerable anxiety and isolation; she has daily feelings of dejection, apathy and pessimism that characterize a socially uncomfortable and lonely woman. She appeared to have drifted into a psychotic episode typified by regressive behavior, physical impassivity and shutting down of emotional expression and behavioral initiative. She was described as feeling anxious and aggrieved, moody and ambivalent. Her possible diagnoses entertained from this profile include schizoaffective disorder, generalized anxiety disorder and PTSD. A designated doctor evaluation performed by a psychiatrist on 03/07/2011 diagnosed her with Factitious disorder, acute stress reaction, resolved, and Borderline Personality disorder.

The current attending physician has diagnosed the patient with PTSD and chronic severe pain disorder and requested the following procedures: CBT, both problem focused and emotion focused, augmented by antidepressant and antipsychotic medication and outpatient narcotic detoxification when appropriate, twice weekly for 12 sessions; medical group psychotherapy to encourage and facilitate acquisition of constructive social attitudes and skills, weekly for 12 sessions; medical biofeedback for chronic, severe pain as a component of CBT, twice weekly for 12 sessions; 3 hours of objective psychological testing and urine drug screen to determine the presence of absence of illicit drug use.

The insurance reviewers have denied these procedures. The drug screen was denied as the reviewer notes that there are no orthopedic records to determine if the patient was prescribed any opiates or minor tranquilizers and the patient is not using any medications including psychiatric medications at the time of review. There is no indication in the record that the patient is using illegal drugs or abusing any legal drugs and has no prior history of such.

Another reviewer denied the other procedures. The rationale is that "without objective evidence to support a diagnosis of PTSD or severe depression, the requested therapies are not supported by ODG. The reviewer states that psychological testing was offered as a partial certification but declined by the attending physician. The reviewer also stated that the MCMI-III identified a possible schizoid personality disorder and schizoaffective disorder, which are not readily treatable with individual psychotherapy. The report does not identify any findings that would support a diagnosis of PTSD.

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

The patient suffered a significant trauma at work during the robbery. She was then re-traumatized in a MVA, sustaining both psychological and physical injuries that now require treatment. The Designated Doctor and reviewers disparaging the patient's evaluations and diagnosis complicate the case. The Designated Doctor concludes that the patient's diagnosis is really Factitious Disorder

and the insurance reviewer concludes that the diagnosis is really schizoaffective disorder and schizoid personality disorder.

The records indicate that the presentation, symptoms and psychological testing are all compatible with a diagnosis of PTSD. The patient meets all DSM-IV criteria for PTSD, including exposure to a traumatic event in which she feared for her life as well as the subsequent symptoms. Although the reviewer calls for "objective tests", there are no objective tests other than patient history available to make the diagnosis. Furthermore, the findings on the MCMI-III show only symptoms, all of which are completely compatible with the diagnosis of PTSD. These symptoms include anxiety, depression, mistrust, paranoia, brief psychosis, irritability, poor social skills and more. All of these symptoms are common in patients with severe PTSD. In fact, the impression from the MCMI-III lists PTSD as part of the differential diagnosis. The test can only be interpreted in context with the clinical presentation of the patient. Thus, the reviewer's focus on the diagnosis of schizoaffective disorder in the differential diagnosis makes no clinical sense, as the patient's history is completely incompatible with such a diagnosis. Furthermore, the patient's irritability, anger and suspiciousness of her previous psychiatrist, Dr., is also compatible with a person suffering from PTSD. Also, the patient's severe reaction that led to her MVA is completely compatible with PTSD. Finally, the history and mental status exam described by the Designated Doctor is compatible with a diagnosis of PTSD.

The reviewer finds Psychological Testing - 3 hours – 96101 is not medically necessary. The records are more than adequate to diagnose this patient with PTSD, and the profile created by the MCMI-III, while failing to give the final correct diagnosis, should be sufficient to give the treatment team the information needed to begin treatment.

The reviewer finds that Cognitive Behavioral Therapy 2 x weekly x 12 weeks – 90806 and Group Psychotherapy Therapy 1 x Weekly x 12 weeks – 90853 and Biofeedback Therapy 2 x Weekly x 12 weeks – 90901 are medically necessary. Aggressively treating such a severe PTSD patient offers a far better chance of recovery than giving only a few sessions, evaluating them for success (which happens only slowly in PTSD and may not even be evident after only 6 to 10 sessions) and then proceeding. ODG Appendix D does allow exceptions as the treatment plan being authorized in cases such as this that are complicated by co-morbidities.

The reviewer finds that Urine Drug Screen – 80101 and Psychological Testing - 3 hours – 96101 are not medically necessary. There is no information in the record to justify this test. There are no substance abuse issues evident in the records reviewed.

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be partially overturned. The reviewer finds that Cognitive Behavioral Therapy 2 x weekly x 12 weeks – 90806 and Group Psychotherapy Therapy 1 x Weekly x 12 weeks – 90853 and Biofeedback Therapy 2 x Weekly x 12 weeks – 90901 are medically necessary. The reviewer finds that Urine Drug Screen – 80101 and Psychological Testing - 3 hours – 96101 are not medically necessary.

#### **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)