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### Notice of Independent Review Decision

**DATE OF REVIEW:** May 13, 2011

**IRO CASE #:**

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

Psychotherapy 1 time per week for 6 weeks.

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

M.D., Board Certified in Psychiatry.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The requested service, psychotherapy 1 time per week for 6 weeks, is not medically necessary for treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was injured on xx/xx/xx while working as a. He was working on a that was on an overhead jack when the jack slipped two feet and the struck him in the head. He suffered a sprain/strain to his neck and upper back. His diagnoses are: cervical sprain/strain, left arm radiculopathy and thoracic sprain/strain. His CT scans and x-rays showed only minimal arthritis. He is receiving Ultram 50 mg 4 times daily as needed and Flexeril 10 mg twice daily as needed. He has been referred for physical therapy (PT). The patient

has been returned to light-duty restrictions. He was referred for a behavioral medicine consultation on 3/14/11. The evaluation noted mild depression and mild anxiety on the Beck Depression Inventory and the Beck Anxiety Index. He showed significant fear avoidance of physical activity in general as well as significant fear avoidance of work. His clinical interview revealed continued pain, frustration and anger, irritability and restlessness, and sleep disturbance. His symptoms interfere with his daily routine. A request was made for six sessions of once weekly individual psychotherapy to educate the patient about pain, decrease depression and anxiety and educate him about sleep hygiene. At issue is whether the requested service is medically necessary for treatment of the patient's medical condition.

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

Review of the submitted behavioral medicine evaluation shows that the patient is experiencing only mild anxiety and depression. The other findings of irritability, anger and frustration are typical of an acute injury. Although a finding of fear avoidance was noted, there is insufficient evidence at this time to show that it is hampering his recovery. Specifically, the patient has had minimal treatment so far. He has only received two medications to take on an as needed basis. Official Disability Guidelines (ODG) require that the individual begin physical therapy initially and then, if he fails to progress, cognitive behavioral therapy can be added to help him learn coping strategies. Documentation of lack of progress with PT has not been provided. As such, I have determined that the requested service is not medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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)