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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: October/07/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual psychotherapy 6 sessions

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

M.D., Board Certified Physical Medicine and Rehabilitation and Pain Management

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
Utilization Reviews, 08/17/11, 09/16/11
Response to denial letter dated 08/17/11
Treatment progress report dated 08/05/11
Office visit note dated 03/23/11
Peer review and supplemental report dated 03/01/11 and 05/09/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient was lifting a heavy door and noted immediate pain in his mid back, low back and right leg. Peer review supplement dated 05/09/11 indicates that diagnosis is a lumbar strain with radicular features. The patient was recommended to undergo epidural steroid injection and continue medication management. Treatment progress report of 08/05/11 reports diagnoses are pain disorder associated with psychological factors and a general medical condition and adjustment disorder with mixed anxiety and depressed mood. A chronic pain management program was recommended. Current medications include Hydrocodone, Lyrica and Amitriptyline. The patient has completed 6 sessions of individual psychotherapy to date. BDI improved from 13 to 10 and BAI from 11 to 9.

Initial request for individual psychotherapy 6 sessions was non-certified on 08/17/11 noting that the patient has completed 6 sessions of individual psychotherapy to date and no meaningful functional improvement has been obtained. Documentation also indicated that the patient was approved for injections, but refused to have them. The patient was approved for 6 sessions of physical therapy, but did not attend. This non-compliance with treatment recommendations was not addressed in the current evaluation. The injury is over 2 years old, the patient's presentation is consistent with a chronic pain syndrome and chronic pain disorder is diagnosed. Current evidence based guidelines note that there is no quality evidence to support the independent/unimodal provision of CBT for patients with chronic pain syndrome. Cognitive therapy 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. Appeal letter indicates that the patient has improved with individual psychotherapy to date and that the patient did undergo one injection with some improvement noted. The denial was upheld on appeal dated 09/16/11 noting that depression and anxiety scores are within the normal range. The patient is not experiencing significant symptoms of psychological distress and has had the opportunity to participate in psychological treatment with little overall progress noted and no progression to return to work.

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

According to the records, this patient has completed 6 sessions of individual psychotherapy to date without significant progress documented. The patient has Beck scales that are in the normal range and do not document significant symptoms of depression and anxiety. There is no indication that the patient has been placed on psychotropic medications for the treatment of anxiety and depression. The Official Disability Guidelines note that the gold standard of treatment is a combination of medication management and individual psychotherapy. Given the current clinical data, the reviewer finds there is not a medical necessity at this time for Individual psychotherapy 6 sessions.

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)