

SENT VIA EMAIL OR FAX ON
Sep/08/2011

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cognitive Behavioral Therapy for post Traumatic Stress Disorder 24 sessions over 90 days twice a week

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

PMR

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

1. Cover sheet and working documents
2. Utilization review determination dated 08/05/11, 08/15/11
3. Specific and subsequent medical report dated 08/03/11
4. Psychiatric evaluation dated 11/24/10
5. PPA and biofeedback baseline study dated 11/24/10
6. Reference material
7. Handwritten progress note dated 05/18/11, 05/17/11, 05/11/11, 05/10/11, 05/04/11, 05/03/11, 04/27/11, 04/26/11, 04/20/11, 04/19/11
8. Health insurance claim forms
9. MMPI-2 extended score report dated 04/18/11

PATIENT CLINICAL HISTORY SUMMARY

Initial request for cognitive behavioral therapy was non-certified on 08/05/11 noting the request exceeds guideline recommendations. The denial was upheld on appeal on 08/15/11 noting that the patient's improvements with therapy completed to date are unclear and there is a lack of evidence of how severe the patient's case is.

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

Based on the clinical information provided, the request for Cognitive behavioral therapy for post traumatic stress disorder 24 sessions over 90 days twice a week is not recommended as medically necessary, and the two previous denials are upheld. The patient has completed 10 sessions of CBT to date; however, the patient's objective, functional response to these sessions is not submitted for review to establish efficacy of treatment and support additional sessions. The Official Disability Guidelines support an initial trial of up to 6 sessions with up to 13-20 total visits with evidence of objective functional improvement. Given the lack of documented improvement with the sessions completed to date, the request is not indicated as 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)