

# Applied Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Nov/07/2012

**IRO CASE #:**

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

Individual Psychotherapy 1 X 4 weeks

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

Anesthesiology/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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Cover sheet and working documents  
Peer review report dated 01/11/12  
Report of medical evaluation dated 07/18/12  
Peer review report dated 08/06/12  
Patient face sheet  
Health and behavioral reassessment dated 09/24/12  
Behavioral health treatment preauthorization request dated 10/01/12  
Utilization review determination dated 10/04/12  
Reconsideration behavioral health treatment preauthorization request dated 10/12/12  
Utilization review determination dated 10/19/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient reported he hurt his back while lifting. Peer review dated 01/11/12 indicates that the patient was seen and diagnosed with lumbar sprain/strain, lumbar radiculitis, cervical sprain/strain, cervical radiculitis and thoracic sprain/strain. Treatment to date includes x-rays, physical therapy, diagnostic testing and medication management. The extent of the compensable work injury is a lumbar sprain/strain and possible cervical sprain/strain. It is more probable than not that the effects of the sprains/strains that were self-limiting should have resolved by this time. Designated doctor evaluation dated 07/18/12 indicates that diagnoses are cervical and

lumbar sprain/strain. The patient was determined to have reached maximum medical improvement as of 01/10/12 with 0% whole person impairment. Health and behavioral reassessment dated 09/24/12 indicates that the patient underwent epidural steroid injection on 10/19/11, facet medial branch blocks on 03/20/12 and facet rhizotomy on 05/01/12. Current medications are amitriptyline, hydrocodone-acetaminophen and Meloxicam. BDI is 16 and BAI is 30. Diagnoses are pain disorder associated with both psychological factors and a general medical condition and anxiety disorder nos.

Initial request for individual psychotherapy was non-certified on 10/04/12 noting that the utilized psychometric instruments are inadequate/inappropriate to elucidate the pain problem, explicate psychological dysfunction or inform differential diagnosis in this case, and there is no substantive behavior analysis to provide relevant clinical/diagnostic information. There is no documentation of the patient's present functional status and ADL. Given the above, it is difficult to appreciate how four sessions of individual psychotherapy could materially affect this patient's functional status. Reconsideration request indicates that the patient is having trouble managing his pain and has difficulty with sleep hygiene. He is sleeping 6 fragmented hours. The patient reports difficulty with activities of daily living. The denial was upheld on appeal dated 10/19/12 noting that the patient's presentation is consistent with a chronic pain disorder and the evaluation diagnoses a chronic pain. ACOEM guidelines state: "There is no quality evidence to support the independent/unimodal provision of CBT for treatment of patients with chronic pain syndrome". There have been no current or recent PT sessions. The claimant worked for some 6 months post-injury with restrictions and was then terminated. These issues indicate that the request is not consistent with the requirement that psychological treatments only be provided for "an appropriately identified patient".

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

Based on the clinical information provided, the request for individual psychotherapy 1 x 4 weeks is not recommended as medically necessary, and the two previous denials are upheld. The patient's subjective complaints outweigh any objective findings. The patient has been diagnosed with cervical and lumbar sprain/strain which should have resolved at this time. The patient has been determined to have reached maximum medical improvement by a designated doctor as of 01/10/12 with 0% whole person impairment. There is no confirmation through validity testing that the patient's reported symptoms are accurate. Therefore, the request is not medically necessary.

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

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**