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Notice of Independent Review Decision

Date notice sent to all parties: 4/24/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual Psychotherapy 1 x Wk x 6 Wks to Lumbar Spine 90834

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

Texas Licensed Board Certified Family Medicine Physician

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 of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. 3/26/13 and 3/5/13 Denial Letters
2. 4/9/13 IRO Request
3. 2/28/13 Behavioral Treatment Preauthorization Request
4. 3/12/13 Reconsideration Behavioral Treatment Preauthorization Request with response to denial rationale
5. Injury 1 Patient Face Sheet
6. 2/26/13 Injury 1 notes
7. 3/14/13 Radiology Report on Lumbar Spine
8. 3/1/13 Functional Capacity Evaluation
9. 3/14/13 MD evaluation
10. 3/14/12 MRI of Lumbar Spine report
11. 9/13/12 MD Disability Determination evaluation
12. 5/31/12 Electrodiagnostic report

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured at work on or around xx/xx/xx. The mechanism of injury involved pulling a heavy dolly. Notes suggest that the patient has not responded to conservative care and a suggestion was made for surgical intervention by Dr.. An initial behavioral assessment was performed on 2/26/13. The patient's pain levels were 10/10 with or without medications. A Beck Anxiety Inventory was a 20 and Beck Depression Inventory was a score of 28. This indicates moderate depression and significant fear avoidance of work. There is mention that the patient has no vocational plan or goals. His notes confirm an MRI with L5-S1 disc herniation to the right but he has a normal EMG. A surgeon found objective evidence of radiculopathy with decreased strength and change in reflex in an S1 pattern and he recommended surgery on 3/14/13.

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

The denial for individual psychotherapy 1 visit per week for 6 weeks is upheld. This patient has undergone conservative care since February 2012. He has been seen by a surgeon who recommends surgical intervention for an L5-S1 disc herniation. ODG criteria suggest that psychotherapy should be provided in conjunction with physical therapy. There is no indication that physical therapy is planned along with this psychotherapy treatment. Additionally, the ODG only recommend 3-4 visits of psychotherapy over 2 weeks and this request exceeds

the guidelines.

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)**