

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/09/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 4 sessions of individual psychotherapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Psychiatry

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. It is the opinion of the reviewer that the request for 4 sessions of individual psychotherapy is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 09/03/13, 09/19/13
Notice to utilization review agent dated 09/24/13
Initial behavioral medicine consultation dated 08/09/13
Reconsideration request dated 09/11/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped and fell into the truck injuring his left shoulder. Per initial behavioral medicine consultation dated 08/09/13, treatment to date includes x-rays, MRI, 1 unsuccessful shoulder injection and 10 rehab sessions. The patient has been recommended for surgical intervention, and surgery has been rescheduled two times in the past few months and at the time was rescheduled for 08/16/13. Current medication is Percocet. BDI is 0 and BAI is 8. Diagnosis is adjustment disorder, unspecified.

Initial request for 4 sessions of individual psychotherapy was non-certified on 09/03/13 noting that the patient does not have elevated BDI, BAI or FABQ scores. There is no evidence of delayed recovery due to identifiable psychological stressors. Reconsideration dated 09/11/13 indicates that the patient is at risk for a delayed recovery. The denial was upheld on appeal dated 09/19/13 noting that it is not clear that the patient even qualifies as having a chronic versus an acute pain state. He rates very low on scales for anxiety and depression such that it is considered that he is not suffering from either condition. He is already almost one month postoperative and is said to be quite eager to return to work. There is absolutely no work avoidance described.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND

CONCLUSIONS USED TO SUPPORT THE DECISION: Per initial behavioral medicine consultation dated 08/09/13, the patient presents with minimal anxiety and depression based on Beck scales. The patient does not present with significant fear avoidance. The patient is not currently taking any psychotropic medications. The submitted records fail to establish that the patient presents with significant psychological issues which have impeded his progress in treatment completed to date. There are no postoperative treatment records submitted for review. As such, it is the opinion of the reviewer that the request for 4 sessions of individual psychotherapy is not recommended 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)