AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: January 19, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

6 Sessions of Individual Psychotherapy visits between 11/8/2013 and 1/7/2014

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

This physician is Board Certified Psychiatrist with over 26 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

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:

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a year old male who was injured at work on xx/xx/xx while unloading when a forklift pushed him against a roller system causing an injury to his back.

: Encounter Note. Chief complaint: back and chest wall pain. PE: back: right flank area T5 to iliac crest area is TTP it looks normal, ROM-Ff to knees, BE more painful, rotation to left is painful, reflexes, strength and sensation are fine in lower extremities. X-ray: 2 view lumbar spine and 1 view chest: mild degenerative disease. Assessment: contusion and sprain. Medication: Ultram and Vicodin. Follow up Thursday, work status is restricted.

04-05-11: Office Visit. Claimant complained the his condition is worsening overall with pain 2-6/10, sharp, stabbing and lightening-like pain into his bilateral lower

extremity with minimal muscle guarding noted in the lumbar spine. Sustained sitting, standing, bending, twisting minimally with gait increases his pain and discomfort. PE: lumbar spine: ROM: 61 degrees flexion, 10 degrees extension, left and right lateral bending of 21 degrees and 22 degrees. There is pain at extreme. Palpation of the bilateral lumbar paraspinal shows moderate myofascial irritation and minimal muscle guarding L5-S1. Orthopedic evaluation: + Nachlas, disk compression, and bilateral sciatic notch test, + SLR on left at 57 degrees with a + Lasegue and on the right at 60 degrees with a + Lasegue. Neurologic examination to the lower extremity shows deep tendon reflexes are +2/+4 and difficulty with heel and toe walk secondary to pain. Clinical Impression: 1. Lumbar sprain-strain, rule out disk injury, 2. On-the-job injury. Treatment plan: follow up in one week, maintain modified work status for one week, PT 3x for 4 weeks, MRI ordered for the lumbar spine, referred to for medication management and interpretation for trigger point injections.

04-26-11: MRI Lumbar Spine / Impression: 1. Posterior central, left paracentral, and posterolateral mild disc protrusion at L4/5 with mild left neural canal narrowing. 2. Left posterolateral mild disc bulge at L3/4. 3. Minimal posterior central disc bulge at L5-S1.

04-28-11: Office Visit. Claimant is currently taking metformin, Dalmane, Flexeril, Hydrocodone and Norco. PE: claimant noted to be in moderate distress. Deep tendon reflexes are +2/4 on lower extremity reflexes. Upon orthopedic evaluation, it is noted that the claimant has a + SLR at 55 degrees on the right and a + Kemp's on the bilaterally. Upon palpation it is noted that there is moderate myospasms in the paravertebral musculature of the lumbar spine. Guarding is noted upon palpation. He also has antalgic gait due to pain that he is experiencing in his right leg. The claimant has difficulty performing heel to tow walk. ROM: flexion 48 degrees, extension 10 degrees, right lateral flexion are 10 degrees and left lateral flexion are 14 degrees. Treatment history: conservative treatment to include examinations, PT, and medications. Discussion: Claimant is not at MMI for his low back pain, right groin pain, and right leg pain. The claimant did suffer a work related accident and the described mechanism injury correlates directly to the complaints that he was suffering from right now. HE is a potential surgical candidate and should proceed with a MRI and EMG/NCV.

05-06-11: Initial Diagnostic Screening. Claimant presented with chief complaint of mood disturbances, anxiety disorder, sleep disorder, vocational concerns, psychosocial stressors, and physical limitations. He was referred for initial/limited diagnostic screening for anxiety, depression, significant mental stress, physical/somatic symptoms and psychosocial symptoms related to claimant's affect. Current medications: Tramadol, Norco, Flexeril, Dalmane, Zanaflex and medications for diabetes and HTN. Clinical Impression: Claimant reported physical/somatic symptoms or psychosocial symptoms related to his affect and physical symptoms which began at the time of injury. On the PPD, claimant rated his pain as a 10/10, which indicated agonizing pain, the worst pain possible. On the PES, he scored a 90.5, which indicates a moderate to severe pain experience. He reported very often feeling the following: I am depressed because of my pain,

thinking “it is so hard to do anything when I have pain”, feeling the pain can get worse and worrying about his family. Claimant scored a 21 on the McGill Pain Questionnaire. He reported the following pain sensations: stabbing, tight, pricking, frightful and intense. He reported feeling the pain continuously and reported the severity of his pain as horrible. Administration of the BAI was 31, which indicates a severe level of anxiety. He reported severely feeling trembling and heat, moderately experiencing: inability to relax, fear of the worst happening, terrified, scared, heart pounding, dizzy, unsteady, shaky, and face flushed. BDI=35, which indicated he is experiencing severe levels of depression with the following symptoms: feeling sad and unable to snap out of it, pessimism toward the future, crying spells, irritability, suicidal thoughts (with no plans), inability to make decisions, feeling is he being punished, disappointment in self, worried about his physical appearance and physical problems, fatigue, sleep difficulties, lack of appetite, decrease in libido, inability to work. Sleep Questionnaire=51, with the following problems: waking up during sleep, waking up too early in the morning, can’t stop thinking while trying to fall asleep, legs jerking during sleep, and a strange feeling at the beginning of sleep. HE reported that his sleep disturbances are caused or made worse by physical pain, personal stress, frustration and anger, and sleep disturbances is a habit now. He reported having trouble sleeping 6 out of 7 nights per week and reported agitation and sleep disturbance symptoms started immediately after the injury. FABQ=20 on the PSS and 42 on the WSS, giving a total score of 62. He has an elevated fear-avoidance outlook and would benefit from an educational approach in therapy that would address these behaviors and outlook. Revised Oswestry/Neck Pain/Modified back pain questionnaire = 66 which indicated crippling level of disability. HE reported the pain intensity as severe and that it does not vary, inability to work, inability to concentrate, lacking a social life due to pain, and inability to travel for more than 2 hours. Diagnostic Impression: Axis I: 309.28 adjustment disorder, with mixed anxiety and depressed mood, V62.2 occupation problem; Axis II: 799.9 diagnosis deferred; Axis III: 847.2 lumbar; PSS Related to Injury: physical health, primary support group/family, occupational/work, economic/financial, access to health care services. Severity: 4; Axis V: GAF current: 50, serious with moderate coping. GAF prior to injury: 3-4, moderate to severe, 68. Treatment Plan: Individual Psychotherapy 6 units 1 x weekly for 6 weeks approved. Treatment Goals: 1. Decrease BDI by 6 points, 2. Decrease BAI by 6 points, 3. Decrease sleep questionnaire by 10 points, 4. Assist in developing an appropriate vocational plan.

05-23-11: Office Visit. The claimant presented with pain ranging 1.5-6/10 from the lumbar spine to the bilateral lower extremity with numbness, tingling, burning, sharp stabbing pain, and lightening-like pain. He has some weakness, more on the left than the right hand side that is aggravated by daily living activities and rest, heat packs, stretching, and medication management help overall condition. PE: No significant changes at this time. Clinical Impression: 1. Lumbar sprain-strain, rule out lumbar disk injury, 2. Lumbar nerve root irritation, rule out lumbar radiculopathy. Treatment Plan: follow up in 2 weeks, maintain no work status for 2 weeks, setup lower extremity EMG/NCV, refer to interventional pain

management and orthopedic evaluation for the lumbar spine, continue medication management, and check on pre-authorization for PT.

05-27-11: Treatment Progress Notes. Problem List: depressed mood, anxiety over vocational future, hopelessness, sorry over physical illness/incompetency. Treatment: will start physical therapy next week – 3 x weeks. Clinical status: claimant is depressed due to worthlessness, recent death of nephew and he couldn't go due to medical condition and appointments. Psychological stressors: claimant stated weakness in right leg/knee, return to work, wants to go to English classes. Treatment Plan: individual therapy 1x week and attend all follow-up appointments, take medication as prescribed, communicate with providers as needed.

05-27-11: Interpretation of Neurodiagnostic Test dictated. Claimant complained of low back pain and bilateral lower extremity pain. Clinical Impression: 1. There is electrodiagnostic evidence of mildly active right L4/5 lumbar radiculopathies based on the electromyographic findings. Denervating potentials were identified on EMG without concormitant reinnervation. This finding is suggestive of an acute to sub-acute process. Lumbar spine neuroimaging correlation is advised to be considered if clinically indicated. 2. There is electrodiagnostic evidence of a mild, distal and symmetric, sensorimotor, moxed demyelinative and axonal, and lower limbs peripheral polyneuropathy consistent with the claimant's history of diabetes. 3. The prolonged tibial and lateral plantar distal latencies are likely reflective of the demyelinating component of the above-mentioned PN, although focal compression neuropathies at the level of the ankle (Tarsal Tunnel Syndrome) cannot be ruled out. If clinically indicated, bilateral medial and lateral plantar motor and midsole mixed NCS may be considered to further assess possible plantar neuropathies in this claimant. Furthermore, plain film radiographs should probably be obtained to exclude extrinsic factors, such as exostoses, malunions, or osteochondromas that cause direct nerve compression. There is no evidence of plexus pathology, focal peroneal neuropathies in their ankle segments, or myopathies. Primary Diagnosis: Radiculopathy.

06-06-11: Office Visit. Claimant complained of lumbar pain 2-6/10, primarily in the lumbar spine radiating into the right lower extremity, aggravated by daily living activities with weakness into the right lower extremity. Medication management, rest, stretching, and heat packs decrease his pain and discomfort. PE: + bilateral sciatic notch test, disk compression, and Nachlas. ROM for the lumbar spine showed minimal change. There is point tenderness noted moderately and chronic myofascial irritation of the bilateral lumbar paraspinals. SLR + on the left at 55 degrees with a + Lasegue and on the right at 58 degrees with + Bragard. EMG/NCV showed a + right L4/5 lumbar radiculopathy. Clinical Impression: lumbar disk injury L4/5, L5/S1, lumbar radiculopathy, right L4 nerve and right L5 nerve. Treatment Plan: follow up in 2 weeks, no work status throughout this period, continue PT, referred to for determination regarding ESI, continue medication management per, referred to for consideration regarding orthopedic review of the lumbar spine.

06-06-11: Treatment Progress Notes. Claimant expressed concerns whether his condition will improve or worsen with all the treatments. He continued PT and medication management. Clinical status: Claimant reported depressed mood focused more on financial strain caused by injury and concerned most about right knee. Psychological stressors: financial strain, multiple medical appointments/treatments, family pressure, anxiety over work failure. GAF: 52. Treatment Plan: Individual therapy weekly, attend follow up appointments, medication as prescribed, and communicate with providers as needed.

06-09-11: Consultation. Claimant complained of continued problem with back pain, right leg pain, tingling and numbness in the right groin and pain in the right lower extremity. The pain is 5-8/10 and continues to be worse since date of accident. Any meaningful activity is causing more pain, PT is helping a little bit, and sleep cycle is disrupted. Allergy to ibuprofen. Current medication: muscle relaxers, anti-inflammatories, pain medication and muscle relaxers. Past medical history: DM, HTN. Social history: history of smoking, negative for alcohol abuse. PE: Neurological Exam: reflexes are diminished, gait, and walk with a limp. Musculoskeletal Exam: Lumbar Spine: Showed right paravertebral muscle spasm, right illolumbar trigger points are palpable, facets slightly tender, trigger points in the right iliocostals, sensations diminished in the right L4/5 distribution, paresthesias on the right side, ROM normal. Assessment: 1. Chronic radiculitis, work-related injury with L4/5 disc herniation and L3/4 disc protrusion at the point in time and an MRI correlates and physical symptoms match the pathology. Plan: transforaminal ESI at right L3/4 and L4/5 under fluoroscopy. The claimant is having radicular-type pain unresponsive to conventional noninvasive treatments such as PT, rehabilitation and the use of medication for more than four weeks. Request an immediate approval for right L3/4 and L4/5 transforaminal ESI. Continue medication management and PT.

7-08-11: Treatment Progress Notes. Claimant continued with depressed mood and hopelessness. He has continued to attend appointments. Claimant reported over use of Norco (double dosed) and was informed on negative effects of this if repeated. Clinical Status: He reported increased hopelessness, recent high pain days, and being frustrated with pain. He stated that he wanted to get better. Psychosocial stressors: chronic pain, financial difficulties, worrying about sending money to, anxiety over occupational future. Treatment Plan: continue IT, attend all appointments as scheduled, and take meds as prescribed.

08-25-11: MMI Determination Claimant is not currently at MMI for his low back pain, right groin pain and right leg pain. He did suffer a work related injury and the described mechanism injury correlates with the complaints of pain. He is a potential surgical candidate and should proceed with all conservative care to try and prevent surgery on his low back. Therefore, he will not be at MMI as of 08/25/11 and will be expected to be placed at MMI as of 12/25/11.

09-15-11: Follow-up Note. Claimant was denied ESI and currently suffered from increased lower back pain and pain radiating into the lower extremities with pain 9/10. Current medications: hydrocodone, Lyrica and muscle relaxers. PE:

positive for joint pain. Lumbar spine: claimant walks with a cane, has right paravertebral muscle spasm and right iliocostalis muscle spasm as well. Facets remain tender L3-L5 levels, right-sided greater than left, paresthesias along the right side L4 and L5 distribution and SLR + right side at 35 degrees, heel and toe walking is also difficult. Assessment: lower back pain, right lower extremity radiculitis, lumbar stenosis, nerve root impingement confirmed by both MRI and EMG studies. Plan: Request approval of right L4-5 and L5-S1 transforaminal ESI, continue current medication as prescribed, and follow up in two weeks following his injection to document pain relief.

11-17-11: Addendum Report of Medical Evaluation. Claimant complained of pain 3-6/10 and complaint of not being able to bend forward. He has a hard time putting on shoes and socks. HE has pain in his lower back, down his right leg into his knee. He claimed he has to sit to shower, sleep on one side and has to get up every 10 minutes from sitting. The pain in his left leg he claimed used to go all the way down to his ankle, but now goes only down to his knee. Prior he had feeling of numbness in his right leg but no longer complained of this. Pain medications seemed to help. Summary and Comments: Diagnosis: 1. Contusion to the back with resulting lumbosacral strain/sprain, compensable injury. Cannot claim herniated disk or any other problems with his lumbosacral spine at this time. Request that an unrelated physician review MRI of lumbar spine in order to determine MMI. Addendum 12/16/11: Repeat MRI of lumbar spine completed. Impression: mild loss of normal lumbar lordosis without evidence of listhesis or focal marrow signal abnormality. Disc desiccation is noted at L3-4 with disc bulging and mild facet arthropathy resulting in mild spinal canal stenosis. The disc bulge appeared to abut the right L4 nerve root within the spinal canal. At L4-5 there was disc bulging and bilateral facet arthropathy. The disc bulge appeared to efface the L5 nerve root on the left. Request a neurological evaluation. The claimant is not at MMI at this time and is a surgical candidate. Extent of injuries: lumbar contusion, strain/sprain and disc herniation at L3/4 and L4/5. With appropriate evaluation and treatment, MMI should be obtained in about 3 months.

12-14-11: Noncontrast RMI lumbar spine. Impression: L3-4 and L4-5 disc bulges effacing the bilateral nerve roots, as discussed above.

02-29-12: FCE. Recommendations: The claimant is currently overall functioning in the light capacity of work, according to the dictionary of Occupational Titles. Recommendation for this claimant would be to continue his lumbar spine treatment protocol as suggested by ODG Guidelines; our objective will be to improve his body mechanics, increasing overall endurance, strength, ROM and decrease pain and pain medication. Claimant would benefit from CPMP.

04-06-12: Initial Diagnostic Screening. The claimant has chief complaint of mood disturbances, anxiety disorder, sleep disorder, vocational concerns, psychosocial stressors, and physical limitations. Current medications: Tramadol, Norco, Flexeril and Dalmane. Clinical Impression: Claimant reported anxiety, depression, sleep disturbance, and physical symptoms which began at the time of injury 2/20/11. Therapeutic strategies were provided to assist in alleviating pain

symptoms. Diagnostic Impression: Axis I: 307.89 pain disorder associated with work related injury medical condition and psychological factors, 309.28 adjustment disorder, with mixed anxiety and depressed mood, V62.2 occupation problem; Axis II: 799.9 diagnosis deferred; Axis III: 847.2 lumbar; PSS Related to Injury: physical health, primary support group/family, occupational/work, economic/financial, access to health care services. Severity: 3-4 moderate to severe; Axis V: GAF current: 53, serious episodes. GAF prior to injury: 70, average in all areas. Treatment Plan: Outpatient chronic pain management 5 x week when approved for 10 days. Treatment Goals: 1. Decrease BDI by 6 points, 2. Decrease BAI by 6 points, 3. Decrease sleep questionnaire by 7 points, 4. Assist in improving functional restoration by reduction of reported pain levels by 2 points, 10 points on the pain experience scale, and 10% on the modified Beck Pain Disability. 5. Assist in developing an appropriate vocational plan. 6. Develop an appropriate narcotic extinction medication protocol for claimant in order to address concerns related to medications

05-01-12: Office Note. Claimant complained of lumbar spine pain. Current medications: Norco 7.5/325. PE: Recently suffered URI with cough. He stated that hydrocodone gave a lot of relief. His pain is most sever in the right lower lumbar and radicular into the right leg. He is awaiting authorization for ESI. Treatment plan: continue current pain medication regimen, wait for ESI auth, and return in one month.

05-29-12: IRO. Reason for denial: AS noted in the Division mandated ODG, such programs are indicated when they are proven successful. No such documentation was presented as to the efficacy of this program. Additionally, there needs to be evidence on the part of the claimant to want to improve. As noted by several examiners, there were signs of symptoms magnification and histrionic behavior and the like, which indicated that there is a very likely possibility of a negative outcome with this course of therapy. The claimant has not responded to any intervention noted to date. Thus, when considering the long list of criteria that are to be met, and note that three of these items are not met (5, 7, 8), and tempered by point that there is little observable motivation on the part of the injured employee to improve, the request cannot be certified.

09-05-12: Initial Diagnostic Screening. The claimant has chief complaint of mood disturbances, anxiety disorder, sleep disorder, vocational concerns, psychosocial stressors, and physical limitations. Current medications: Tramadol, Norco, Flexeril and Dalmane. Clinical Impression: Claimant reported anxiety, depression, sleep disturbance, and physical symptoms which began at the time of injury 2/20/11. Therapeutic strategies were provided to assist in alleviating pain symptoms. Diagnostic Impression: Axis I: 307.89 pain disorder associated with work related injury medical condition and psychological factors, 309.28 adjustment disorder, with mixed anxiety and depressed mood, V62.2 occupation problem; Axis II: 799.9 diagnosis deferred; Axis III: 847.2 lumbar; PSS Related to Injury: physical health, primary support group/family, occupational/work, economic/financial, access to health care services. Severity: 3-4 moderate to severe; Axis V: GAF current: 53, serious episodes. GAF prior to injury: 70,

average in all areas. Treatment Plan: Individual Psychotherapy 6 units 1 x week when approved for 6 weeks. Treatment Goals: 1. Decrease BDI by 6 points, 2. Decrease BAI by 6 points, 3. Decrease sleep questionnaire by 7 points, 4. Assist in improving functional restoration by reduction of reported pain levels by 2 points, 10 points on the pain experience scale, and 10% on the modified Beck Pain Disability. 5. Assist in developing an appropriate vocational plan. 6. Develop an appropriate narcotic extinction medication protocol for claimant in order to address concerns related to medications

10-04-12: Office Visit. Complained of pain 2.5-7/10 with discomfort characterized as numbness, tingling, deep burning pain, and at times weakness. PE: ROM: flexion 68 degrees, moderate pain, extension 10 degrees, moderate pain, left and right lateral bending of approximately 23 degrees. Examination for the bilateral lumbar paraspinals showed chronic myofascial irritation. Assessment for strength of the trunk is a 4+/5, reduced secondary to pain. Neurological examination to the lower extremity does reveal the right Achilles +1/+4, all other reflexes +2/+4. Examination for strength showed right EHL 4+/5, right quad 4+/5, left quad 5/5, left EHL 4-/5. Clinical Impression: lumbar sprain-strain complicated by lumbar disk injury L3/4, L4/5, HNP, work related. Treatment Plan: follow up in 6 weeks, modified work status for 6 weeks, medication management, and setup with an examination for orthopedic review of the lumbar spine on 10-15-12.

02-25-13: Office Note. The claimant presented with lumbar pain 2-7/10 and continued difficulty overall with his lumbar spine, increased pain and discomfort with daily living activities, characterized as deep, burning, and dull ache, which extends in a radicular manner into the lower extremity. The radicular complaints are numbness, tingling, sharp stabbing pain, and weakness. Medication management, stretching, use of heat and cold packs, and massage all help decrease pain and discomfort. PE: ROM of lumbar spine reveled 66 degrees flexion, 11 degrees extension, and bilateral bending of 23 degrees and 24 degrees, strength 4+/5, reduced secondary to pain. Orthopaedic evaluation: positive bilateral sciatic notch test, disk compression, and Nachlas. Examination for palpation shows point tenderness revealing chronic myofascial irritation of the lumbar paraspinals. There is point tenderness between the L4/5, L5/S1 interspinous ligaments. Deep tendon reflexes into the lower extremity shoe +2/+4 except for the right Achilles, +1/+4. Strength evaluation on the right hand side EHL, 4+/5, right quad 4+/5, left quad 5/5, and left EHL 4-/5. Clinical Impression: Lumbar disk injury, L3/4, L4/5, HNP, lumbar sprain-strain with contusion, work related. Treatment Plan: follow up 60 days, maintain modified work status for 6-days, and continue medication management though there is a dispute, setup examination for determination regarding epidural steroid injections.

09-24-13: Treatment Progress Report. Problem List/Diagnosis: 307.89 pain disorder associated with Work Related Injury Medical Condition and Psychological Factors, 309.28 adjustment disorder, with mixed anxiety and depressed mood, V62.2 Occupation problem, 847.2 lumbar sprain/strain. Diagnostic Impression: Axis I: 307.89 pain disorder associated with work related injury medical condition and psychological factors, 309.28 adjustment disorder, with mixed anxiety and

depressed mood, V62.2 occupation problem; Axis II: 799.9 diagnosis deferred; Axis III: 847.2 Lumbar sprain/strain; Psychological Stressors Related to Injury: physical health, primary support group/family, occupational work, economic/financial, access to health care services; PSS severity: 4; Axis V: current GAF 50; serious with moderate coping; prior to injury GAF 3-4, moderate to severe, 68. Treatment Goals/Techniques: 1. Decrease BDI by 6 points; 2. Decrease BAI by 6 points; 3. Decrease Sleep Questionnaire by 5 points; 4. Decrease McGill Pain Questionnaire by 6 points.

11-18-13: UR performed. Reason for denial: In this case, individual psychotherapy does not appear warranted for this claimant at this time. A review of the submitted medical documents indicates that the claimant had been treated for an industrial low back injury and pain-associated anxiety and depressed mood. A review of the 09/24/13 progress report indicated that 8 individual psychotherapy sessions were completed to date. The claimant's current medications were reported as: Tramadol 100mg – 2 times daily for pain; Norco 7.5/325 – 4 times daily for pain; Flexeril 10mg – 3 times daily for muscle spasm; and Dalmane for sleep. The provider's objective findings consisted of discussion of the claimant scored outcome measures detailed above. A review of the included findings indicated that (with exception of the McGill Pain Questionnaire) the claimant's condition; in terms of function, fear avoidance beliefs, anxiety, depression and sleep; worsened (from moderate to severe) during the 8 individual psychotherapy sessions completed to date. The ODG does recommend cognitive behavioral therapy for depression. The ODG recommend an initial trial of 6 visits over 6 weeks; and with evidence of objective functional improvement, up to 13-20 individual sessions over 13-20 weeks. The available medical documents fail to provide evidence that the claimant exhibited any functional improvement with the initial individual therapy sessions; in fact the cited 09/24/13 progress appears to indicate that the claimant's condition actually worsened. Based on this discussion, additional individual psychotherapy sessions would not appear medically necessary. Therefore, the prospective request for 6 individual psychotherapy visits is recommended non-certified.

12-18-13: UR performed. Reason for denial: Upon review of the submitted records, the reviewer is in agreement with the prior non-certification. The 09/24/13 progress report by, MS, LPC indicated that 8 individual psychotherapy sessions were completed to date. The available medical documents failed to provide evidence that the claimant exhibited any functional improvements with the initial individual therapy sessions. The claimant's fear avoidance beliefs, anxiety, depression and sleep worsened (from moderate to severe) during the 8 individual psychotherapy sessions. Additional individual psychotherapy visits is recommended non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld and agreed upon. after the accident, the claimant's global assessment of functioning (GAF) was a 50. His GAF only improved to a 53 with the eight therapy sessions. The 9/24/2013 report

written by, MS, LPC indicated is GAF has dropped to a 50. The claimant has been afforded the 8 individual psychotherapy sessions with static results. Based on his static mental health condition, additional individual psychotherapy visits is recommended non-certified. Therefore after review of medical records and documentation submitted, the request for 6 Sessions of Individual Psychotherapy visits between 11/8/2013 and 1/7/2014 is denied.

Per ODG:

Behavioral treatment	**ODG cognitive behavioral therapy (CBT) guidelines for low back problems:** Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these "at risk" patients should be physical therapy exercise instruction, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone: - Initial trial of 3-4 psychotherapy visits over 2 weeks - With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions) - Psychotherapy visits are generally separate from physical therapy visits, and psychotherapy may be appropriate after physical therapy has been exhausted

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)**