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### Notice of Independent Review Decision

**Date notice sent to all parties:** 06/26/14 (AMENDED 07/01/14)

**IRO CASE #:**

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

Six sessions of individual psychotherapy over three months

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

Licensed by the Texas State Board of Examiners of Psychologists

**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.

Six sessions of individual psychotherapy over three months - Overturned

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

On xxxxx examined the patient. The handwritten notes were mostly illegible, but his medications were Ibuprofen and Norco. He had been seen in a DDE regarding return to work status. His medications were continued and a pain management program was recommended. The patient underwent an FCE on 11/14/13. He was functioning in the light PDL and his previous employment required the medium PDL. He had undergone left knee surgery on 09/04/12. He

was unable to perform a floor level lift and his shoulder lifting and overhead lifting was limited secondary to pain. It was felt his efforts were valid. It was noted on floor to knuckle lifting, knuckle to shoulder lifting, and shoulder to overhead lifting had to be stopped, as the patient lost his balance on the first try of each test. The patient underwent another FCE on 12/17/13. He continued to function in the light PDL. He had completed 10 days of a pain management program at that time. It was felt his efforts were valid. He was unable to perform some testing due to pain and some of the testing increased his pain. Continuation of the pain management program was recommended. A chronic pain management program progress report dated 12/24/13 noted the patient had attended 10 sessions. His current medications were Norco and Ibuprofen. The recent FCE was reviewed. His BAI score was 18, which indicated mild symptoms of anxiety. His BDI score was 17, which indicated a mild to moderate level of depression. It was felt he required an additional 10 days of the program. Ms. provided a chronic pain management program discharge summary on 03/21/14. He had attended 20 sessions. Norco was to be continued and an orthopedic evaluation was pending. It was noted a CCH was done and the extent of injury was favorable and included all diagnoses for the knee. His BAI score was 14, which indicated mild symptoms of anxiety. His BDI score was 15, which indicated mild to moderate symptoms of depression. Six hours of individual psychotherapy was recommended at that time to address his affective and pain related symptoms. On 04/02/14, an unknown provider examined the patient. His diagnosis was a left knee sprain/strain status post meniscal tear. It was noted they were waiting on approval for an MRI. It was noted there was no change in his condition. Norco with two refills was prescribed. On 04/02/14 provided an adverse determination for the requested six sessions of individual psychotherapy over three months. Another chronic pain management program discharge summary dated 04/07/14 was reviewed. He was being treated. It was felt he had a medial meniscal tear. It was noted the individual psychotherapy had been denied and an appeal letter dated 04/07/14 was referenced. His BAI and BDI scores were essentially unchanged. The six sessions of individual therapy over three months was again recommended. On 04/07/14, provided a response to the denial letter. She noted the issue with the patient's claim. The sessions were again recommended, as it was felt aftercare treatment would allow the doctors to monitor affective and pain symptoms, as well as vocational support. On 05/27/14, provided another adverse determination for the requested six sessions of individual therapy over three months.

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

This patient sustained a left knee injury and he received 20 days of an intensive outpatient chronic pain management program. It appears he meets the requirements of medical necessity per the ODG Guidelines for automated approval of six individual psychotherapy sessions with an adjustment disorder diagnosis. Furthermore, according to the ODG Integrated Treatment/Disability Duration Guidelines for Chronic Pain, "suggestions for treatment post program should be well documented and provided to the referring physician. The patient

may require time limited less intensive post treatment with the program itself. Defined goals for these interventions and planned duration should be specified.” This is well documented who requested the six sessions of outpatient psychotherapy for the patient. Therefore, the requested six sessions of individual psychotherapy over three months is appropriate and in accordance with the ODG and the previous adverse determinations should be overturned at this time.

**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**
    - Integrated Treatment/Disability Duration Guidelines for Chronic Pain
  - 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)
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- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**