

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Mar/06/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 12 sessions of cognitive behavioral therapy

**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 12 sessions of cognitive behavioral therapy is not recommended as medically necessary.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. He injured his right knee. Psychiatric evaluation dated 08/13/13 indicates that he describes gross insomnia. He has frequent nightmares and crying spells twice daily. Diagnosis is posttraumatic stress disorder with severe depressive symptoms. Designated doctor evaluation dated 09/11/13 indicates that the patient has been treated with conservative care including physical therapy for 4 weeks that helped and injection x 1 that helped for a week. Diagnoses are closed head injury and right knee contusion. The patient was determined to have reached maximum medical improvement as of 06/25/13 with 0% whole person impairment. Designated doctor evaluation dated 12/13/13 indicates that right knee surgery is pending. Extent of injury is right knee contusion, anterior horn of lateral meniscus tear, closed head injury and posttraumatic stress disorder. Specific and subsequent medical report dated 01/09/14 indicates that right knee pain persists from 5-10/10. Sleep has improved. He is somewhat less agitated and overwhelmed. Crying spells continue daily. Medications are listed as citalopram and trazodone. BDI report dated 01/21/14 indicates that score is 21.

Initial request for 12 sessions of cognitive behavioral therapy was non-certified on 01/16/14 noting it is unclear how many sessions of cognitive behavioral therapy the patient has completed to date. Current evidence based guidelines support ongoing cognitive behavioral therapy with evidence of symptom improvement. There are no objective measures of improvement provided. Additionally, there are no specific, time-limited treatment goals provided.

The patient's current medications are not listed. The denial was upheld on appeal dated 01/30/14 noting that the only objective measurable testing scores other than the T-score was provided to support he has experienced significant improvement to support additional therapy. The number of sessions the patient has attended in total was not provided to determine whether the request exceeds guideline recommendations.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient was involved in a work-related accident on xx/xx/xx when he fell at work. Per psychiatric evaluation dated 08/13/13, diagnosis is posttraumatic stress disorder with severe depressive symptoms. The submitted records indicate that the patient has undergone some psychological treatment to date; however, the number of sessions completed to date and the patient's objective response are not provided. The Official Disability Guidelines Mental Illness and Stress Chapter support ongoing treatment only with evidence of symptom improvement. Given the lack of documented efficacy of treatment, the request for additional cognitive behavioral therapy is not supported. As such, it is the opinion of the reviewer that the request for 12 sessions of cognitive behavioral therapy 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)