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Notice of Independent Review Decision

DATE OF REVIEW: September 25, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual psychotherapy one time per week for four weeks.

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

M.D., Board Certified in 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)

The requested individual psychotherapy one time per week for four weeks is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx, in which he injured his lower spine. The patient is status post laminectomy and discectomy in 2013. The documentation submitted for review indicates that the patient had four individual psychotherapy sessions in November 2013. On 6/24/14 the patient was evaluated for individual psychotherapy treatment. The evaluation noted a fear avoidance beliefs score of 42, a Beck Depression Inventory (BDI) score of 6 and Beck Anxiety Inventory (BAI) score of 4. The patient was noted to sleep only 3.5 hours per night. The assessment noted that the patient did not present with any current risk factors. He was given diagnoses of insomnia disorder and somatic symptom disorder, with predominant pain, persistent, mild. A request was made for four sessions of individual

psychotherapy. An office visit dated 8/15/14 notes that the patient is now three months since his two-level transforaminal lumbar interbody fusion (TLIF) at L4-5 and lumbosacral. He no longer uses a cane to walk. He does have some erector spinae spasm from time to time, but his preoperative pain appears to be completely resolved. He was referred for physical therapy/work hardening and a left sacroiliac (SI) joint injection for symptomatic relief.

The Carrier indicates in its denial letter dated 9/11/14 that the patient made improvements in psychological testing scores from 3/10/14 to the assessment on 6/24/14, as such the request is non-certified.

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

According to Official Disability Guidelines (ODG) the patient does not meet criteria for individual psychotherapy. Per ODG, an initial trial of 3-4 psychotherapy visits over two weeks is recommended and with evidence of objective functional improvement up to 6-10 visits over 5-6 weeks is recommended. According to the psychological assessment performed on 6/24/14, the provider did not find any current risk factors for recovery. The evaluation identified a high fear avoidance factor. Moreover, the more recent note from the patient's surgeon dated 8/15/14 indicates that the surgical procedure has now alleviated the patient's pain and he is no longer using a cane to ambulate. Therefore, the indication for the four sessions of individual therapy is no longer present. The surgeon has referred the patient for physical therapy/work hardening. It does not appear that the patient has any barriers to this treatment modality. Therefore, there is no longer an indication for further psychotherapy. In accordance with the above, I have determined that the requested individual psychotherapy one time per week for four weeks is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)