Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

DATE NOTICE SENT TO ALL PARTIES: Feb/15/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Four individual counseling sessions, (1 x per week x 4 weeks)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Physical Medicine and Rehabilitation; Board Certified Pain Medicine

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

[X] 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 <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for Four individual counseling sessions, (1 x per week x 4 weeks) is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. He was pushing some wooden planks up to another worker on the second level when the planks slipped and fell backwards on him. The patient fell to the ground. He injured his low back and right shoulder. Initial mental health evaluation dated XX/XX/XX indicates that the patient presents with a chief complaint of chronic pain to the low back and right shoulder rated as 8/10. He reports increased anxiety and irritability associated with his injury. He is sleeping about 4 hours nightly due to the pain which exacerbates his anxiety. He also admits to depressed mood including poor concentration and feeling lethargic due to the severe pain. Treatment to date is listed as one epidural steroid injection in XXXX, three back surgeries in XXXX, XXXX and XXXX, and one shoulder surgery in XXXX. He also had physical therapy without relief. He is motivated to change and return to work. Current medications are tramadol and Zanaflex. He denies suicidal ideation. BDI is 30 and BAI is 35. Diagnosis is pain disorder with related psychological factors. The patient was recommended for four individual counseling sessions to reduce anxiety and increase coping skills and to reduce symptoms of depression and improve concentration.

Initial request for four individual counseling sessions, 1 x per week x 4 weeks was non-certified on XX/XX/XX noting that the records available for review do not provide any data to indicate that the claimant is presently with any type of a thought disorder. Past treatment has included access to treatment in the form of a work hardening program as well as a comprehensive pain management program. It would be realistic to expect that the claimant would be fully educated on proper pain management strategies/coping mechanisms when an individual has received access to the amount of treatment in multidisciplinary programs that has previously been provided to the claimant. The denial was upheld on appeal dated XX/XX/XX noting that the claimant has been provided psychological services. There is no indication of the effectiveness of these services. He has had multidisciplinary care in the form of work hardening, chronic pain management programs and psychotherapy sessions.

At this point in his treatment process, he should be very familiar with pain coping mechanisms.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in XX/XXXX. The submitted prior utilization review determinations indicate that the patient has undergone prior work hardening program, chronic pain management program and individual psychotherapy; however, there is no specific information provided regarding this treatment including treatment records, dates of service and patient response. There is no indication that the patient has undergone any recent psychometric testing with validity measures to confirm that the patient's reported symptoms are accurate. The patient is not currently taking any psychotropic medications. Given the patient's reported treatment to date, the patient should have been educated o proper pain management strategies and coping mechanisms. As such, it is the opinion of the reviewer that the request for Four individual counseling sessions, (1 x per week x 4 weeks) is not recommended as medically necessary and the prior denials are upheld.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)