

Vanguard MedReview, Inc.

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January 2, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions of cognitive behavioral therapy, 12 sessions of group psychotherapy, and 12 sessions of biofeedback.

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

This case was reviewed by a Board Certified Doctor of Psychiatry with over 25 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XXXX with an occupational incident dated XXXX. XXXX accidentally XXXX. The diagnosis was post-traumatic stress disorder with major depressive symptoms, acute, severe.

XXXX: UR performed by XXXX, **Rational for Denial:** On XXXX the case was discussed with XXXX. XXXX stated that the claimant has made progress despite significant stressors in XXXX life to include the XXXX as well as XXXX. XXXX stated that prozosin has reduced nightmare frequency and the claimant has reportedly made some progress towards resuming XXXX hobbies. XXXX stated that the claimant has only recently made the type of progress needed to consider re-entry to the work force but that the claimant still has a long way to go. XXXX clarified that biofeedback should not have been requested. Recommend adverse determination for the requests for 12 sessions of cognitive behavioral therapy, 12 sessions of group psychotherapy, and 12 sessions of biofeedback. While there continues to be report of improvement, there is no clear evidence of significant ongoing recovery. The claimant has had treatment for well over XXXX and an apparent report of improvement at every preauthorization request for additional services. Even with mild incremental improvement, the claimant should be substantially better after such a long time of active treatment. It is unclear that any such improvement

has been substantiated.

XXXX: UR performed by XXXX, **Rationale for Denial:** While there continues to be report of improvement, there is no clear evidence of significant ongoing recovery. The claimant has had treatment for well over XXXX and an apparent report of improvement at every preauthorization request for additional services. Even with mild incremental improvement, the claimant should be substantially better after such a long time of active treatment. It is unclear that any such improvement has been substantiated. An adverse determination is rendered.

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

The medical documentation to make a determination was reviewed. The patient was first placed on workman's compensation in XXXX after XXXX. The medical records have been updated to show that XXXX has made some improvement, although there is no clear evidence of significant ongoing recovery. The biofeedback is denied (it was not requested). The need for more CBT is not indicated at this time as it appears XXXX symptoms associated with the claim are static. XXXX has other stressors that could well be addressed in therapy, but not under workman's compensation.

Per ODG:

ODG Psychotherapy Guidelines:

- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)
- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.

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)**