

Notice of Independent Review Decision

DATE OF REVIEW: 03/27/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1 X 6 weeks

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the individual psychotherapy 1 X 6 weeks is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Letter from– 03/17/08
- Notice of Assignment of Independent Review Organization – 03/17/08
- Behavioral Health Individual Psychotherapy Preauthorization Request – 01/10/08, 01/30/08
- Environmental Intervention – 90882 – 01/14/08, 02/06/08

- Adverse Determination Letter – 01/16/08, 02/06/08
- Reconsideration: Request for Behavioral Health Treatment – 01/30/08
- Insurance Verification Form For Workers' Compensation Insurance – 12/27/07
- Initial Behavioral Medicine Consultation – 01/04/08
- Report of MRI of the cervical spine – 11/29/07
- Report of MRI of the upper extremity joint – 10/10/07
- Report of nerve conduction studies-upper extremities – 11/20/07
- History and Physical by Dr. – 01/15/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when she developed pain in her right shoulder after walking dogs which was required in her job. She complained of pain in her right shoulder, as well as in her neck on both sides radiating into her anterior chest wall and on the right side down to the mid axillary line approximately T10. The patient has been treated with analgesics and physical therapy.

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

This patient was referred for behavioral medicine consultation for assessment to determine her need for behavioral health care intervention, secondary to observed emotional distress related to pain and injury as a result of her work accident. The testing determined she suffered from a diagnosis of adjustment disorder with mixed anxiety and depressed mood, chronic, secondary to work injury. It was further determined that she experienced significant changes in her lifestyle, as well as physical, vocational and psychosocial functioning since her work injury. It was recommended she receive 6 sessions of individual psychotherapy. The ODG's allow for initial trial of 6 weeks of psychotherapy. These services can also be performed in conjunction with appropriate medication. The medical record provides sufficient documentation to clinically justify the requested services. Therefore, it is medically necessary for this patient to receive the requested individual psychotherapy 1 X 6 weeks.

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)