

Notice of Independent Review Decision

DATE OF REVIEW: 11/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy sessions 1 X 6

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

The TMF physician reviewer is board certified in family practice 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 sessions 1 X6 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 10/30/09
- Notification of determination – 09/21/09, 10/19/09
- Carrier submission from lawyers – 11/04/09

- Notice of disputed issue(s) and refusal to pay benefits . – 1/02/09
- Initial injury evaluation from Medical Clinic – 07/31/08
- Office visit notes from unknown provider – 08/01/08 to 08/25/08
- Report of MRI of the left knee – 08/20/08
- Designated Doctor Evaluation – 10/10/08
- Letter – 01/06/09
- Whole person impairment evaluation – 01/19/09
- Report of medical evaluation by Dr. – 03/13/09
- Review of Medical History & Physical Exam by Dr. – 03/13/09
- Report of functional capacity evaluation – 03/24/09
- Letter from Dr. – 03/25/09
- Report of examination by Dr. – 08/31/09
- Physical therapy evaluation – 09/03/09
- Initial behavioral medicine consultation – 09/10/09
- Environmental intervention by Dr. – 09/21/09
- Physical therapy progress note – 09/24/09 to 09/28/09
- Report of impairment rating by Dr. – 10/20/09
- Insurance verification for Workers' Compensation Insurance – 07/08/09
- Referral for evaluation and treatment from Dr. – 07/31/09
- Behavioral health individual psychotherapy preauthorization request by Dr. – 09/16/09, 10/12/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was welding under a railcar, moved his left leg to get into a better position, causing his left knee to pop followed by sharp pain. The patient has been diagnosed with adjustment disorder with mixed anxiety and depressed mood, chronic, secondary to work injury; pain disorder associated with psychological factors, chronic, secondary to work injury, depressive disorder, in full remission. The treating physician has recommended that the patient undergo psychotherapy sessions at 1 X 6.

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

The patient is suffering from depression secondary to the work-related injury. The proposed psychotherapy is a very important part in keeping the patient in the work force as well as his overall well being. Therefore, it is determined that the

Individual psychotherapy sessions 1 X 6 is medically necessary to treat this patient's 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 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)