Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 18, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Individual psychotherapy (90806) 1X 6 weeks; Biofeedback therapy (90901) 1X6 weeks

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
Unk	90806		Prosp	6					Upheld
Unk	90901		Prosp	6					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-19 pages

Respondent records- a total of 94 pages of records received to include but not limited to:

letter 11.2.09; ODG-TWC guidelines Shoulder (acute & chronic); Health records 8.6.09-9.23.09; report, Dr. 6.4.08-7.9.08; MRI Rt shoulder 3.16.05; MRI C-spine 6.7.06; Inc report 5.8.09; DWC form 69; DDE report 8.1.08; request IRO forms; letter 9.1.09, 10.1.09

Requestor records- a total of 44 pages of records received to include but not limited to:
Health records 6.11.09-10.30.09; TDI letter 10.29.09; letter 9.1.09, 10.1.09
MRI C-spine 6.7.06; report, Dr. 6.4.08; MRI RT shoulder 3.16.05

PATIENT CLINICAL HISTORY [SUMMARY]:

The records presented for review begin with a pre-authorization request forwarded by Psy.D. for individual psychotherapy and biofeedback therapy. One time a week for six weeks (1 x w x 6). The request for the services came from D.C. based on an adjustment to injury and pain. This request was non-certified.

There was a request for reconsideration. The reason for the original non-certification was a lack of clear objective data, the reviewer was uncertain as to how much psychotherapy had been completed and was unable to speak with the requesting provider.

With this reconsideration, MS dismissed the physician generated peer review as "irrelevant," determining that they do not hold presumptive weight. Further, Mr. could not establish how much psychotherapy or behavioral health services had been completed in this case. Therefore, it would be his opinion that one should start at the beginning.

The medial records also include notations of epidural catheters and local anesthetic on several occasions. MRI of the right shoulder completed on March 16, 2005 noted a supraspinatus tendinopathy. MRI of the cervical spine noted a small (2 mm) disc herniation at the C5-6 level.

Dr. completed a peer review in May 2009 outlining the medical records reviewed, the history of the event to date, the interventions and studies (i.e. negative EMG) completed and opined that the treatment for the right shoulder injury appeared to be excessive and that further interventions would not be indicated. Dr. cited the AMA Guides to the Evaluation of Permanent Impairment, 4th edition and the Division mandated Official Disability Guidelines as his references.

Also of note is the August 2008 Designated Doctor report of Dr. noting that maximum medical improvement had been reached with a 9% whole person impairment rating.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the Division mandated Official Disability Guidelines individual psychotherapy is warranted under a certain circumstances "ODG Psychotherapy Guidelines:

- Initial trial of 6 visits over 6 weeks
- With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions) …" (Leichsenring, 2008)

This is a lady who has seen multiple providers. Each evaluation failed to identify any specific acute pathology even remotely related to the reported mechanism of injury. There were ordinary disease of life degenerative changes; however, none rose to the level of pathology equal to the pain complaints offered. With each new referral and evaluation came refreshed complaints and no objective findings noted. Thus, in that it is not clear what psychotherapy was completed, what

the response to prior interventions was and given that the complaints far exceed the objective parameters noted; there is no clear clinical indication for this therapy or if there is any reasonable expectation of any sort of positive outcome. Further, the dismissal of the PhD. Psychologist peer review in favor of the intern assessment offered by MS, LPC is pandering at best. If this type of care has failed prior, one does not see any valid reason presented to repeat this modality. Therefore, it is deemed that the requested Individual psychotherapy (90806) 1X 6 weeks; Biofeedback therapy (90901) 1X6 weeks are not medically necessary.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX 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)