

SENT VIA EMAIL OR FAX ON
Dec/23/2009

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

6 sessions of individual counseling

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

Clinical psychologist; Member American Academy of Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 10/12/09 and 11/5/09

PPE 7/31/09

FCE 7/31/09

Work Hardening Treatment Plan 7/21/09 thru 8/4/09

Healthcare 3/16/09 thru 7/14/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a work-related injury on x/xx/xx while performing her usual job duties, which included repetitive lifting. Upon lifting a "tote", she experienced pain in her left hand, and reported this to her supervisor the next day. She was put on light duty for three months, followed by intensive rehabilitation to include: conservative care, medications, physical therapy, E-stim, surgery, and work hardening program. Records indicate the patient has been in an off-work and in a restricted return to work setting since this injury. Report states and PPE shows that patient continues to be in a sedentary/light PDL and patient reports wanting to work more hours with fewer limitations.

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

Records submitted for review include a PPE, FCE, and two requests for a chronic pain management program earlier this year, which were denied and are not the subject of this

request. The subject of this request was for 6 individual therapy sessions, but since no recent evaluation or documentation was included to support this request, it cannot be considered medically necessary at this time.

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

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)