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Notice of Independent Review Decision

DATE OF REVIEW: December 1, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Six sessions of Individual Psychotherapy.

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

GENERAL AND FORENSIC PSYCHIATRIST
BOARD CERTIFIED BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- Healthcare Systems, 10/20/10, 11/12/10, 04/29/11, 05/17/11, 05/16/11, 05/17/11, 06/17/11
- Texas Workers' Compensation Work Status Report, 11/12/10, 04/29/11, 05/17/11, 05/17/11, 06/17/11, 07/09/11
- M.D., 07/09/11
- D.C., 08/09/11, 08/16/11, 08/30/11, 09/27/11, 10/25/11
- M.D., 08/10/11, 08/30/11, 09/07/11, 10/05/11
- M.D., 09/01/11, 10/20/11
- Behavioral Health Associates, Inc., 09/01/11, 09/28/11, 10/04/11, 10/25/11
- 10/04/11, 11/01/11
- Mental Health Evaluation/Treatment Request, 08/10/11
- Imaging, 04/14/10

Medical records from the Provider include:

- Texas Department of Insurance, 11/10/11
- Behavioral Health Associates, Inc., 09/01/11, 10/04/11
- M.D., 08/10/11, 09/07/11, 10/05/11
- Mental Health Evaluation/Treatment Request, 08/10/11
- M.D., 07/09/11
- Imaging, 04/14/10
- D.C., 09/27/11, 08/30/11, 08/16/11

PATIENT CLINICAL HISTORY:

My finding is going to be to overturn the review outcome.

The patient was injured on xx/xx/xx. She was struck in the head. She did not lose consciousness, but had some nausea and lightheadedness. She subsequently had multiple persistent complaints including headache, intermittent left upper extremity tingling, bilateral intermittent arm weakness, some light sensitivity, left medial scapular pain, lightheadedness, shortness of breath, and she might have passed out. She reports depression. She has been treated with a number of conservative treatments without substantive improvement.

The patient had a followup Designated Doctor Examination with M.D., on July 9, 2011. He concluded her diagnoses were concussion resolved, cervical strain/sprain resolved, and depression with panic disorder not part of the injury. He opined she could return to work.

The patient had an initial psychological evaluation conducted on September 1, 2011. Conclusion from that evaluation was the patient has an adjustment disorder with mixed anxiety and depressed mood and an occupational problem. She was administered a number of psychological tests that suggest psychological overlay to her complaints, and moderate levels of depression and anxiety. A request was made for six sessions of individual therapy to address the anxiety and depression symptoms. This was not authorized. The citation was in the ODG pain chapter. The rational is not clearly specified, though it implies the patient is not an appropriately identified chronic pain patient. On appeal it appears it was non authorized, citing that the symptoms did not appear to be physiologically possible due to the injury as described, and indeed the documented effects of the injury appeared to have long since resolved. As such, the request appeared to be for medical care outside of the effects of the injury and would not be considered reasonable or necessary per peer reviewed literature.

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

While the reviewer may be correct that the symptoms are not related to the injury, the review is on medical necessity of the proposed treatment and not on causation. The requested treatment is for individual psychotherapy for depression and anxiety. The ODG mental section recommends cognitive therapy for depression, panic disorder, and general stress with a recommendation for an initial trial of six visits over six weeks, which is what was requested.

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)