

Notice of Independent Review Decision

DATE OF REVIEW: 11/30/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1x 6 weeks 90806

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

The physician performing this review is Board Certified, American Board of Psychiatry and Neurology. He has been in practice since 1963 and is licensed in the State of Texas.

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.

Original denial upheld upon independent review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 22 page fax 11/10/11 Texas Department of Insurance IRO request, 75 page fax 11/11/11 URA response to disputed services including administrative and medical, 33 page fax 11/16/11 Provider response to disputed services including administrative and medical. Dates of documents range from 07/03/10 to 11/10/11

PATIENT CLINICAL HISTORY [SUMMARY]:

Ms. is now about. She was at the time of her date of injury. She suffered a back sprain, apparently, while attempting to move an ice chest. The description is more elaborate in previous notes that I have at hand. This is an independent review inasmuch as the patient has appealed previous denials of psychotherapy treatment, which had been recommended initially by the treating physician.

The original treating physician was a Dr., who saw the patient. He was the original referring physician for the disputed psychotherapy treatment. The patient was seen for an evaluation shortly after that who is a licensed professional counselor. She recommended a course of six psychotherapy treatments as a result of that evaluation in August of 2011.

There has then been an initial review of that recommendation by a Dr. who is a Ph.D. psychologist, not a physician. A further appeals review was done by a psychologist Ph.D. named. Both such reviews have supported the original denial of the psychotherapy.

It should be observed that a further physical evaluation was done 07/08/11 by M.D. He examined and reevaluated the patient and made recommendations only for pain control and did not address the question of recommended psychotherapy.

The patient had some kind of open heart surgery not described in detail in these notes in 2005. She also had back surgery on two occasions, one in 1986 and one in 2005. She was involved in a car accident and had a rib removed in 1986 as a result of injuries from the accident. It is also noted she had a hysterectomy in 1990, and in another place it says it was a different year so it is unclear to me what year that occurred. There is no great detail provided about any of these surgical efforts.

The patient is reported as being diabetic and as having heart disease, and it is noted that she has the congenital absence of one kidney. Also, I note that on examination she was found to have a stenosis involving spinal nerves.

The actual diagnosis rendered on 08/26/11 is that of lumbar disk disease with radicular pain in the right leg.

It should be borne in mind that I have not had an opportunity to examine this patient or interview her at all and that I am going purely from previous records.

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

In reviewing ODG guidelines, I have found them written up in the paperwork here in several places, and I feel that the patient's psychological complaints as described fail to meet the standards for treatment as expressed in the ODG. It should be borne in mind that the symptomatology is not described either quantitatively or qualitatively in very great detail. I must, however, on the basis of this review support the previous denial of treatment.

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)**