

Notice of Independent Review Decision

**DATE OF REVIEW: 10/29/2010**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Individual psychotherapy 1x6 weeks 90806

**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 general medicine 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 1x6 weeks 90806 is not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 12/14/10
- Notification of Adverse Determination– 09/29/10
- Notification of Reconsideration Determination – 11/01/10
- Letter to TMF – 12/17/10
- Behavioral Health Treatment Preauthorization Request form – 09/24/10, 10/18/10
- Patient Face Sheet from Physician Mgmt. Svc. – 09/16/10
- Individual Psychotherapy Reassessment Notes by Dr. – 11/06/09 to 09/13/10.
- Initial Behavioral Medicine Consultation by Dr. – 07/27/09
- Follow up office visit notes by Dr.– 06/23/10 to 10/12/10

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work-related injury to his right hand on xx/xx/xx when his glove slipped, resulting in a laceration to his right hand. He underwent surgery for laceration repair and tendon repair. In addition, he has been treated with medications and physical therapy. The patient was evaluated for a major depressive disorder and recommendations have been made for individual psychotherapy.

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

Xx year old male involved in injury to right hand in xxxx requiring multiple surgeries and rehab. Patient underwent psychotherapy x12 sessions with minimal/no improvement in depression. Reassessment in 9/10 does not reveal any new findings which would suggest that further therapy would be of any benefit.

**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)