

Notice of Independent Review Decision

DATE OF REVIEW: 06/13/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy x 6 sessions CPT-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 orthopedic surgery 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 x 6 sessions CPT-90806 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 05/25/11
- Decision letter from – 05/06/11, 05/13/11
- One page from ODG TWC Low Back Pain – Behavioral Treatment – 2006
- Preauthorization request from Balance – 05/14/11, 05/10/11
- Appeal letter from LPC – 05/09/11
- Peer to Peer Telephone Conference Note for Appeal – 05/06/11, 05/12/11
- Medication management evaluation notes by Dr. – 04/29/11
- Prescription for Chronic Pain Management by Dr. – 03/08/11
- Individual Treatment plan of care by LPC – 04/29/11
- Initial Mental Health Evaluation by LPC – 04/29/11
- Physical examination by Dr. – 04/29/11
- Office visit notes by Dr. – 10/07/10, 10/25/10
- Designated Doctor Evaluation by Dr. – 06/10/10
- Pages 2 and 3 of what appears to be a History and Physical with no signature page – 06/18/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was working and fell back, hitting his head on a metal stool, This resulted in injury to his neck, upper back and lower back. He has been diagnosed with cervical strain, lumbar strain with contusion and cervical/lumbar degenerative disc disease. He has been treated with conservative care including physical therapy and epidural steroid injections. He continues to be symptomatic and there is a request for individual psychotherapy x 6 sessions CPT-90806.

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

The patient at this time has shown no improvement and continues to be symptomatic with neck and back pain. He has been out of work for least 18 months and is unable to return to the work force. The patient has undergone psychological testing and based on the ODG Guidelines regarding pain control, he meets the criteria for individual psychotherapy. Therefore, it is determined that the individual psychotherapy x 6 sessions CPT-90806 is medically necessary to treat this patient's condition.

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)