

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 2, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Individual psychotherapy 1X6 weeks

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
813.	90806		Prosp	6			9.4.2010	41011563	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a copy of the initial non-certification of request. It would appear that the reason for the not certification was that there was no significant progress documented from the prior treatment protocol. The request was for additional sessions of a failed modality.

It is noted that there was a reconsideration of the request. This reconsideration request was also not certified. The same reason as there was "no indication from the available

determination/information that the patient has made any significant overall improvement in his function.”

The initial behavioral medicine consultation was completed on November 16, 2010. Subsequent to that evaluation, the initial sessions of psychotherapy had been completed.

Additionally, I had reviewed the operative report dated September 10, 2010 to address the closed fracture of the distal radius on the right. Furthermore, a neurologic consultation completed by Dr. noted a diffuse neuropathy of the left ulnar and median nerves distal to the elbow. CT imaging studies completed in November, 2010 were compromised secondary to the hardware in the wrist. Unfortunately, fracture lines were still clearly delineated. This would indicate a less than successful intervention.

Dr. completed his initial consultation on November 12, 2010. It was noted there was a fractured left wrist and a left hip injury. The claimant was to continue with a regular follow-up evaluation by the orthopedic surgeon, was to obtain a second opinion as to appropriate treatment from a separate orthopedic surgeon, and was to continue with physical therapy, a pain management protocol and individual psychotherapy counseling. Dr. continued to evaluate him on a periodic basis to the beginning of January 2011, and now it is noted that there was a lumbar sprain as part of the diagnosis list. There are no medical records presented documenting any utility or efficacy of the individual psychotherapy or that there was any improvement whatsoever.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines the standard for continued psychotherapy is based on “evidence of objective functional improvement.” Based on the records presented for review, there is no competent, objective and confirmable medical evidence that there has been any improvement in the pain complaints, functionality or any other parameter on which to support this request. There was no note from the requesting provider, completed after the two non-certifications, explaining why there should be any change in the determination, what if any improvement had been made and why an additional six sessions of psychotherapy would advance the clinical situation. This lack of data requires that the prior non-certifications not be overturned.

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)