

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/23/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual Psychotherapy 1x4

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

M.D., Board Certified Psychiatry

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 medical necessity exists for each health care service in dispute. The reviewer finds medical necessity is not established for Individual Psychotherapy 1x4.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 07/10/12, 07/27/12
Reconsideration request dated 07/20/12
Referral form dated 06/20/12
Initial behavioral medicine consultation dated 07/03/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male. He suffered a crush injury of his 3rd and 4th digits. The patient's wound was washed and wrapped in gauze. He had x-rays. Per initial behavioral medicine consultation dated 07/03/12, the patient has not undergone any physical therapy. He has not seen a specialist. Current medications are Norco and Keflex. BDI is 6 and BAI is 13. FABQ-W is 29 and FABQ-PA is 8. Diagnosis is pain disorder associated with both psychological factors and a general medical condition, acute.

A request for psychotherapy was denied on 07/10/12 noting that there is no evidence that these minimal to mild psychological symptoms constitute a delay in the "usual time of recovery" from this acute injury. The patient is experiencing acute pain from the injury. With acute pain, "pain is still related to tissue damage" and "is not yet compounded by the motivational, affective, cognitive, and behavioral overlay that is often a frustrating aspect of chronic pain". This is a new injury with acute pain. The patient is actively involved in the continued evaluation and treatment of this new injury. There is no reason to believe that the

current active rehabilitation will be insufficient to restore functional status. Reconsideration letter dated 07/20/12 indicates that the "at risk" for the delayed recovery of the ICD codes 816.02 and 927.3 is 41 days. He has completed 3/6 physical therapy sessions. The denial was upheld on appeal dated 07/27/12 noting that the patient was injured and does not present with significant psychological indicators. The patient has only completed 3 sessions of physical therapy to date, and there is no indication that the patient will not improve with continued active treatment modalities.

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

The patient sustained crush injury and per the submitted clinical records, has only completed 3 of 6 physical therapy visits to date. The patient's objective, functional response to these sessions is not documented. The patient presents with minimal to mild psychological indicators and individual psychotherapy is not supported under the guidelines at this time. Therefore, the reviewer finds medical necessity is not established for Individual Psychotherapy 1x4.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM-AMERICA 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)