



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 12/11/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of individual counseling 2x/week for 3 weeks.

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

The reviewer is a Medical Doctor who is board certified in Psychiatry. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of individual counseling 2x/week for 3 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 10/18/12 preauth request, 10/15/12 vocational rehab eval, 2/24/11 office notes by MD, 8/30/11 initial mental health evaluation, 10/12/12 handwritten office notes by Dr., 8/9/10 hospital notes from , 8/9/10 radiographic report of left hand, 8/9/10 US report, 10/24/12 preauth request, 10/24/12 appeal letter by, 10/12/12 physical exam by Dr., 11/7/11 30 day follow up mental evaluation, 3/18/10 DD report by MD, 11/24/10 operative report,

11/24/10 orders and reports from, 9/28/11 DD report by Dr., and 10/24/11 letter by Dr..

Dr.: 10/23/12 denial letter from, and 11/19/12 denial letter from.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a male who sustained a hand injury on xx/xx/xx while at work. He was working as a xx when his glove and hand were caught in a running machine. He received a crushed injury to his hand that was subsequently treated with surgery, physical rehabilitation and 20 sessions of CPMP between 10/19 and 12/09/11.

Since then he had developed persistent hand pain, limitations of range of hand movements, limitations of weight lifting and secondary depression. Dr. reported, on 8/30/11 of persistent hand pain (6/10), severe depression (BDI 49/63), severe anxiety (BAI 41/63), crying spells, easy irritability and anger resulting in marital tensions, disturbed sleep (3-4H/night). Dr. is recommending 6 additional psychotherapy sessions (2 sessions per week). Re-evaluations by Dr. between 10/12 and 11/7/12 suggest a similar clinical picture and advice of same 6 additional psycho-therapy sessions.

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

The reviewer indicates that additional psycho-therapy sessions, above & beyond completed 20 CPMP sessions, may not add in his recovery process. Therefore, the reviewer recommends denial of 6 additional psycho-therapy sessions, above & beyond completed 20 CPMP sessions.

RATIONALE per ODG Criteria:

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

- (1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts;(d) Failure to restore pre-injury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs;

(e) Development of psychosocial sequel that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention);(f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component;(g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

Based upon the above information, the reviewer finds the requested service to be not medically necessary at this time. Therefore, the requested service is denied.

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)**