

IRO REVIEWER REPORT TEMPLATE -WC



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Notice of Independent Review Decision

Date notice sent to all parties: 1/18/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient individual psychotherapy X6 sessions

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

Texas Licensed Psychologist

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 of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. 1/2/13 and 1/6/13 Denial letters
2. 12/27/12 Mental Health Services Request
3. 8/3/12 Rehabilitation Center Script Image and Patient Intake Evaluation
4. 8/6/12 Rehabilitation Center Custom Evaluation

PATIENT CLINICAL HISTORY [SUMMARY]:

Mr. was injured while working on xx/xx/xx. The following information was obtained from Peer Review by Dr. dated 01/02/13: Claimant was diagnosed with post-concussion syndrome. MRI of brain on 03/22/11 was normal, but claimant's primary care physician reported changes in claimant's behavior since injury.

Neuropsychological evaluation was recommended on 04/21/11. Claimant participated in brain injury rehab program at Pate Rehab and at least 27 counseling sessions thereafter. Claimant has premorbid history of closed head injuries in sports and possibly in the military, as well as Gulf War Syndrome for which he participated in vestibular therapy. Claimant also has history of hyperlipidemia, chronic bronchitis, GERD, renal stones, right TKA, and left shoulder replacement. Claimant's physician recommended work up to rule out sleep apnea. Medications as of 04/02/12 were Advil, Pristiq, Aricept, Protonix, simvastatin, Zocor, Lyrica, trazodone, Depakote, and a nasal spray. There is no provided documentation of neuropsychological evaluation, functional progress with brain injury rehab program, or work up for sleep apnea.

Mental Health Services Request indicates that weekly psychotherapy sessions were conducted from 05/16/12 through 12/27/12. Axis I diagnosis: 293.89

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

Anxiety Disorder due to TBI. Request state that claimant has made "continuous progress", obtained a driver's license, and obtained and maintained employment. Claimant continues to experience anxiety when in crowds and when driving. He is

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oversensitive to irritations and experiences difficulty sustaining attention in noisy restaurants with loud children. Records do not provide documentation of any psychological or neuropsychological testing or any measure of anxiety.

Script Image and Patient Intake Evaluation from Rehabilitation Center dated 08/03/12 stated diagnosis of Post Concussion Syndrome. Custom Evaluation with results of RIPA from Rehabilitation Center dated 08/06/12 indicated difficulty with memory and orientation. The evaluation indicated that claimant displays labored speech with intermittent vowel distortions, difficulty with multisyllabic words and intermittent fluency deficits.

Peer Review report by Dr. states, "It is unclear what etiology may be responsible to any current complaints. Further, there is no documentation of any clinically meaningful ADL dysfunction which might be ascribed to the TBI. He is working independently in a highly technical field; and any current complaints have not been clinically/logically connected to the head injury. There have been an excessive number of treatments provided to date; and I do not find a coherent rationale for treatment of behavioral or psychological problems which might be (and have not been) specifically ascribed to any cognitive deficits or behavioral sequelae of the head injury. I am not able to establish a basis that continuing this treatment is both reasonable and necessary at this time. Non-approval is recommended..... Initial trial of 6 visits over 6 weeks with evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions). [Official Disability Guidelines. (2013). Head]"

Peer Review report by Dr. states, "Per ODG Psychotherapy Guidelines, Initial trial of 6 visits over 6 weeks with evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions). The patient to date has had 28 sessions and there was not a provided clinical rationale for a variance over the identified upper limit of sessions. Therefore, based on the available information, the request is not considered medically necessary at this time and is non-certified. Guidelines Cited: ODG, Head Chapter, Cognitive Therapy."

Claimant has already participated in 27 or 28 sessions of counseling, with diagnosis of 293.89 Anxiety Disorder due to TBI. Provided records do not provide documentation of any measure of anxiety. Provided records do not provide evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition" (DSM-IV criteria for 293.89 Anxiety Disorder due to GMC). Based on the documentation, medical necessity of outpatient psychotherapy X 6 sessions has not been met per ODG guidelines.

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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)