

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: JULY 17, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional Individual Psychotherapy 1xWk x 4 Wks (90834).

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

M.D., Board Certified in 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)

I have determined that the requested Additional Individual Psychotherapy 1xWk x 4 Wks (90834) is not medically necessary for the treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Requests for a Review by an Independent Review Organization dated 6/25/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) 6/26/13.
3. Notice of Case Assignment dated 6/27/13.
4. Patient Face Sheet.
5. Individual Psychotherapy Treatment Re-Assessment Summary dated 5/10/13 and 3/12/13.
6. Behavioral Health Treatment Preauthorization Request dated 6/13/13, 5/28/13, 3/14/13, and 1/8/13.
7. Patient Referral dated 11/28/12.
8. Individual Psychotherapy Preauthorization Request dated 6/13/13.

9. Initial Behavioral Medicine Assessment dated 1/4/13.
10. Progress Note dated 12/17/12.
11. Department of Insurance Report of Medical Evaluation dated 3/15/13.
12. Designated Doctor Evaluation dated 3/15/13.
13. Operative Report dated 6/3/12.
14. Denial documentation dated 6/24/13 and 5/31/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was working with an industrial machine which automatically turned on grabbing his hand, fracturing two fingers and amputating three others on xx/xx/xx. The patient had surgical repair and subsequently was diagnosed with post-traumatic stress disorder (PTSD) and an anxiety disorder. He was subsequently successfully treated with 10 sessions of psychotherapy and eight sessions of occupational therapy. A request was made for additional sessions of psychotherapy once per week for four weeks to treat remaining symptoms of sleep problems and apparent residual PTSD symptoms. The patient has requested authorization and coverage for Individual Psychotherapy 1xWk x 4 Wks (90834).

The URA stated in its first denial that the patient has very little residual pain, rated at 2/10, no reported re-experiencing symptoms, and no reported avoidance symptoms commensurate with the diagnosis of PTSD. No pharmacologic intervention has been made.

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

Per the Official Disability Guidelines (ODG), this patient has had an initial 10 sessions of psychotherapy for treatment of his PTSD diagnosis with good response. Although treatment could be extended for up to one year and include as many as 50 sessions, this is reserved for situations where there is evidence of ongoing severe symptomatology and coexistent medical or psychiatric comorbidity. This patient's records do not include documentation that this patient demonstrates any such features. The patient has made good improvement and there is no evidence that continuing treatment of this nature will present any lasting improvement in the patient's ability to function. Therefore, I have determined the requested Additional Individual Psychotherapy 1xWk x 4 Wks (90834) is not medically necessary for treatment of the patient's medical 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 JUDGMENT, 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)