

# Becket Systems

An Independent Review Organization  
815-A Brazos St #499  
Austin, TX 78701  
Phone: (512) 553-0360  
Fax: (207) 470-1075  
Email: manager@becketsystems.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jul/21/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** individual psychotherapy 1 x 4

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., 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.** It is this reviewer's opinion that medical necessity has not been established for individual psychotherapy 1 x 4.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**PATIENT CLINICAL HISTORY [SUMMARY]:** The injured worker is a female whose date of injury is xx/xx/xx. She reportedly injured her right wrist while performing her customary duties. She complained of right wrist pain, with numbness in her right hand and fingers with burning in her right wrist that radiates up to her elbow. Per initial behavioral health consultation dated 05/28/14, the injured worker's mood was dysphoric; affect was constricted. She did not display cognitive disorders. BDI score was 8 indicating minimal depression. BAI score was 17 indicating moderate anxiety. Diagnosis was anxiety disorder NOS. A request for 4 sessions of individual psychotherapy was non-certified per review dated 06/04/12, noting that there was limited documentation submitted for review with no physical examination and no history of interval medical care, and "simply no explanation provided how/why any psychological services would be indicated and necessary after a noninjury." A reconsideration request was non-certified per utilization review dated 06/23/14, noting that the injured worker was diagnosed with anxiety NOS. in the case discussion with the requesting provider the injured worker was listed as having problems with ADLs. In exploring this it is really interpersonally sensitivity being referred to.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** This is an injured worker who complains or right wrist symptoms with no specific trauma/injury identified. The patient has subjective complaints, but there is no physical examination with objective findings of significant symptomatology of the right wrist/hand. No comprehensive history of treatment to date was provided. Per ODG guidelines for cognitive behavioral therapy, there should be screening for patients with risk factors for delayed recovery. Initial treatment for these "at risk" patients should be physical therapy for exercise instruction. However, there is no indication that the injured worker has received any conservative care for this injury. Findings on psychological

testing were not severe. Based on the clinical information provided, it is this reviewer's opinion that medical necessity has not been established for individual psychotherapy 1 x 4.

**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)