



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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**Notice of Independent Review Decision**

**DATE OF REVIEW: 3/03/2014**

**IRO CASE #**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Psychotherapy 6 sessions over 8 weeks.

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Document Type	Date(s) - Month/Day/Year
Department of Insurance Notice of Case Assignment	2/10/2014
Utilization Review Determinations	1/16/2014-2/05/2014
Response to Denial Letter	1/20/2014
Discharge Summary	12/20/2013
Visit Notes	11/19/2013-12/17/2013

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a man who sustained an injury to his right wrist and arm on xx/xx/xx, diagnosed as complex regional pain syndrome. In late xxxx, he underwent a 20-day comprehensive pain management program involving multiple therapeutic modalities, including several group therapies per day, and weekly individual therapy addressing all aspects of chronic pain, with good outcomes. With “planned treatment successfully completed,” he was deemed capable of light/medium work activities, with vocational goals explored.



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

Per ODG references, the requested “Psychotherapy 6 sessions over 8 weeks” is not medically necessary. Given the successful completion of the 20 day comprehensive pain management program, further psychotherapy sessions are not medically necessary.

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

- 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