

DATE: 03.03.14

Notice of Independent Review

DATE NOTICE SENT TO ALL PARTIES: 03.03.14

IRO CASE #:

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

The reviewer is a licensed Texas psychologist

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Six individual psychotherapy sessions, CPT Code 90837

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- X** Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
309.28	90837		Prosp.				Xx/xx/xx		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Initial letter of denial, 01/16/14, including criteria used in the denial
2. Response from treating facility regarding first denial on 01/20/14
3. Reconsideration on 02/05/14
4. The treating doctor's office notes from 12/28/13 and 10/24/13
5. Records and documents

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant was injured on the job on xx/xx/xx, including an injury to the back, including the cervical and lumbar spines, left elbow, shoulders, and knees. The injuries occurred when the claimant fell. The claimant has had extensive treatment including 24 individual psychotherapy sessions that were authorized, as well as completing a full twenty-day chronic pain management program.

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

Basically, there is not a medical necessity for an additional six psychotherapy sessions that are in dispute. The explanation of the decision, which was to uphold the denial of authorization of six additional 90837 psychotherapy sessions, was based on the ODG cognitive behavioral therapy guidelines for chronic pain with evidence of objective functional improvement. A total of up to six to ten visits over five or six weeks is authorized; however, the claimant has already completed those sessions. There is no evidence that she possesses severe psychological comorbidities such as severe depression, PTSD, or personality disorder. Therefore, the certification is upheld and the request 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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)