

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/26/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual Psychotherapy x 12 visits (for low back pain)

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 10/08/13, 10/23/13
Psychosocial pain assessment form dated 09/25/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient underwent lumbar fusion in 03/2012. The patient has participated in injection therapy and medication management. Psychosocial pain assessment form dated 09/25/13 indicates diagnoses are bipolar I disorder, schizophrenia, alcohol dependence, pain disorder. Current medications are listed as Morphine, Flexeril, Gabapentin, Percocet, Seroquel, Lithium and Propranolol. The patient reports 33 days sobriety and recurrent suicidal ideation. He is not currently under consistent psychiatric care. The patient reports having hallucinations. He reports recurrent suicidal ideation, but denies ideation at this time. He reports seeing a psychiatrist, a therapist and participating in group therapy in the past.

Initial request for individual psychotherapy x 12 visits was non-certified on 10/08/13 was non-certified noting that per telephonic consultation with the requesting provider, the requested sessions were to monitor the claimant over 6 months to see if he would be stable enough to be a candidate for a spinal cord stimulator. She would also work on some coping skills. The patient has significant psychiatric comorbidities. The claimant has had treatment with counseling and group therapy without apparent long term benefit. It is unclear how the requested treatment would have significant impact on the patient's condition in light of the

poor response to prior care. The denial was upheld on appeal dated 10/23/13 noting that the worker suffers from schizophrenia as well as chronic pain. A particular barrier to this has been ETOH abuse. He only has less than one month sobriety at this time.

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

The patient presents with psychiatric comorbidities including bipolar disorder and schizophrenia. He reports seeing a psychiatrist, a therapist and participating in group therapy in the past. There is no documentation of significant sustained benefits secondary to psychological treatment completed to date. Therefore, efficacy of treatment is not established. As such, it is the opinion of the reviewer that the request for individual psychotherapy x 12 visits (for low back pain) is not recommended as medically necessary.

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)