

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 12, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Psychological screening; 96101

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

Clinical psychologist; Member American Association of Pain Management

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

Adverse Determination Letters, 10/19/07, 10/30/07, 2/26/07

ODG Guidelines and Treatment Guidelines

Dr., 9/11/03-3/24/04

Dr., 12/3/02-11/7/07

Therapy and Diagnostics, 11/7/07, 7/3/07, 6/1/06, 7/20/05

Pain Management, 4/13/04, 5/10/04, 11/22/04, 1/23/05, 2/24/05

Operative Report, Dr., 11/22/06

Dr., 5/2/06

MD, 1/8/03

D.C., 3/4/05

X-Ray, Left Shoulder, 2/15/05

Orthopedics, 2/15/05, 1/31/06, 6/27/06

MD, 10/16/03

Radiology Report, 11/10/02

MRI of Lumbar Spine without Contrast, 1/18/03

MRI of Left Shoulder, 1/18/03

Dr. 2/1/05

Dr., 11/11/03

Psychological Center, 11/30/04

EMG, NCS, 1/11/03

MA, LPC, 11/29/04

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female who was injured on xx/xx/xx performing her regular job duties as a xxxxxx. She and a co-worker were in the process of transferring a patient, when she felt onset of pain in her low back. She sought immediate treatment on the date of the injury, to include x-rays. Following this, she continued to experience pain, and over the course of her therapy and treatments has received appropriate diagnostics and interventions to include: MRI's, EMG's, discogram, physical therapy, lumbar ESI's, medication management, and chronic pain management program. Recently, surgery to the low back has been requested and denied twice as not being medically necessary. Current request is for pre-surgical screening.

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

Pre-surgical screening was requested by the surgeon to rule out symptom amplification in this patient. ODG does recommend psychosocial screening for patients where spinal surgery is being considered. This screening is done prior to surgery in order to identify roadblocks to recovery and address these in order to potentiate surgical outcomes. However, since surgery is not currently a consideration (because it has been deemed not medically necessary), there is no reason for pre-surgical screening. In addition, it is impossible to evaluate medical necessity of testing when no specific test battery is requested. ODG recommends numerous tests that are appropriate in different situations, but any request for testing needs to include the tests to be administered and the rationale for these.

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 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)**