

C-IRO, Inc.
An Independent Review Organization
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Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: JULY 15, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Psychological re-evaluation for surgical clearance

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

Clinical psychologist; Member American Academy 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for psychological re-evaluation for surgical clearance.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 4/28/08, /24/08
DC, 6/14/07, 6/16/08
MD, 8/23/07, 5/29/08, 5/1/08, 4/3/08, 3/6/08, 2/7/08, 1/10/08, 12/13/07
MD, 8/30/07
MD, 10/1/07, 11/16/07, 11/28/07, 1/7/08, 2/25/08, 4/7/08
Therapy & Diagnostics, 6/17/08
MRI of Lumbar Spine, 3/18/08, 4/17/07
Psychological Evaluation, 10/10/07
Law Offices, 6/25/08, 6/18/08
ODG, Psychological Screening

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old male who was injured at work on xx/xx/xx while performing his usual job duties. Reports indicate the patient stepped on a chain and someone yanked the chain, causing him to fall and sustain injuries to his low back. He has since received conservative and secondary treatments/diagnostics to include MRIs, x-rays, medications management, physical therapy, and lumbar surgery in xx/xx.

Note of 04/07/08 by the patient's surgeon diagnosed the patient as having lumbar mechanical low back pain at L5-S1, lumbar recurrent radiculitis, lumbar segmental instability at L5-S1, and lumbar post laminectomy syndrome status post lumbar microdiscectomy, laminectomy, foraminotomy, and partial facetectomy at L5-S1 on the left. Current diagnostics show evidence of recurrent disk herniation at L5-S1, segmental instability with retrolisthesis of L3-4, decreased disc height and disc desiccation. Current recommendation is for an anterior lumbar interbody fusion at L5-S1, transsacral approach, and bilateral facet joint fixation. Request is for psychological re-evaluation for surgical clearance. There is no indication in the records provided what tests are being requested or how many hours are expected to accomplish the testing.

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

The request is for psychological re-evaluation for surgical clearance. This particular patient has a history of one failed back surgery, and it would appear that an in-depth interview along with psychological testing would be appropriate to ascertain that patient actually understands the procedure, risks, and benefits, and has a realistic idea about the amount of pain relief he is expecting from the surgery. Additionally, personality and coping mechanisms, as well as depression and anxiety levels need to be formally evaluated to determine if surgery is indicated at this time. . However, there is no indication in the records provided what tests are being requested or how many hours are expected to accomplish the testing. A diagnostic interview of a patient without the accompanying battery of tests is not medically necessary, as it would give no real and responsible information regarding candidacy, and could be used to rubber stamp all surgical requests. The reviewer finds that medical necessity does not exist for psychological re-evaluation for surgical clearance.

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)