



REVIEWER'S REPORT

DATE OF REVIEW: 11/13/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Psychological testing.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.O., Physical Medicine and Rehabilitation and Pain Management

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. CT scan report of the lumbar spine dated 12/21/07, which reads, “Spinal decompression surgery at L4 with pedicular fixation screws at L4/L5 with fusion. Postoperative changes in the posterior spinal soft tissues at L4. No fluid collection or abscess. Recommend further evaluation with contract MRI scan if clinically indicate. Mild disc bulge at L5/S1 without significant central canal narrowing.”
2. I have reviewed various notes submitted entitled Texas Workers’ Compensation Work Status Report from Dr..
3. I reviewed a 07/09/08 note from Dr.. He opined maximum medical improvement was obtained on 07/09/08, and there was no neuromuscular deficit perceived in the lower extremities. He was given an impairment rating of 5%. He recommended a Functional Capacity Evaluation to determine work status.
4. I reviewed notes from Dr., D.C. He performed an impairment evaluation on 07/31/08. I do not have the actual rating he provided.
5. I reviewed a psychological assessment of 08/18/08 from Dr. Ph.D. There was a request from Dr. for psychological testing.

6. I reviewed a Peer Review from Dr., M.D. dated 09/03/08 requesting three hours of psychological testing to help determine if an injured worker is a candidate for four sessions of individual psychotherapy due to chronic low back pain.

7. Dr. has indicated her psychosocial stressors include the persistent of pain and significant change in her normally active lifestyle. She has decreased participation in many activities that she previously enjoyed such as working, going to church, visiting with friends and family, cooking, and working around the house due to her pain, physical limitations, and emotional distress. She also reported that her brother died three weeks ago, and her older son has legal issues as well as a child on the way. She rated the severity of her non-pain related stressors as severe. This was dated 08/19/08. In the report of 08/19/08, her symptoms also included increased panic, inability to breathe when upset with increased irritability and uncontrollable crying and cognitive confusion. The note also indicates fluctuations in appetite, low energy, sleep disturbance, loss of interest in doing things she used to enjoy doing, and the presence of suicidal thoughts, although she has no plans for suicide. She denied any homicidal ideations.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This is an injured employee who sustained a back injury on xx/xx/xx. Previously she had surgery at the L4/L5 level on 05/14/06. She was determined to be at maximum medical improvement on 07/31/08. The injured employee has significant psychosocial stressors, some related to her back injury, and others unrelated. Of concern is her suicidal thoughts, although she does not express a plan to carry that out.

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

The injured employee apparently has significant psychosocial stressors that are impacting her recovery and quality of life. Some of these relate to the physical limitations due to her back injury, and others relate to the problems with her recent brother's death as well as legal problems that her son is having. There has not been any formal testing for depression or anxiety, although she does express symptoms compatible to those as well as some depression. I do believe that a comprehensive psychological assessment would be helpful in plotting future therapeutic intervention, whether it be directly attributable to her back injury, attributable more to her non-work related condition, or a combination of both.

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

(Check any of the following that were used in the course of your review.)

_____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-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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)