

SENT VIA EMAIL OR FAX ON  
Feb/10/2010

## Independent Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/09/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

BHI psychosocial screen as outpatient, cervical and lumbar series

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

Doctor of Medicine (M.D.)  
Board Certified in Orthopaedic Surgery

**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**

OD Guidelines  
Denial Letters 12/4/09 and 12/15/09  
Ortho 5/28/09 thru 1/20/10  
Dr 8/21/09  
Dr. 6/4/09  
Post Discogram CT 1/8/10  
OP Report 1/8/10 and 9/11/09  
Therapy & Diagnostics 11/16/09 thru 1/20/10  
10/12/09  
MRI 6/9/09  
X-Rays 5/28/09 and 1/20/10  
Radiology Chest 5/22/09  
Head/Neck CTA 5/21/09  
Facial Bones CT 5/20/09  
Discharge Summary 5/26/09  
History & Physical 5/20/09  
Consult 5/21/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient suffered a severe traumatic brain injury and temporal bone fracture causing hearing loss and facial paralysis. In addition the patient's upper both cervical and lumbar spinal injuries. Epidural injections improved the cervical problems somewhat but did not help the lumbar radiculopathy and disk disease. Lumbar diskography revealed significant pain at the L5-S1 level. The patient has failed conservative treatment and his spine surgeon is considering operative management particularly in light of the diskography findings. The request for psychosocial evaluation has been denied by the medical insurance company.

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

Psychosocial screening and evaluation prior to lumbar disk surgery particularly fusion is medically reasonable and necessary. It is a prerequisite for spinal fusion according to the ODG guidelines. The IRO reviewer disagrees with the insurance company to deny screening particularly in light of the polytrauma.

**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)