

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 06/13/10

**IRO CASE #:**

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

Individual psychological testing times three, or twelve units, pre-surgical clearance, repeat diagnostic interview, pre-surgical clearance

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Orthopedic Surgery

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
840.4	96101		Prosp.						Overturn
840.4	90801		Peosp.						Overturn

**INFORMATION PROVIDED FOR REVIEW:**

1. Certification of independence of the reviewer.
2. TDI case assignment
3. Letters of denial, 05/10/10, 05/18/10, including the criteria used in the denial
4. Treatment documentation, 02/10/09 through 05/28/10
5. Medical records from 2006 through 2008 are available upon request

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient suffers from chronic neck and shoulder pain after a work-related injury. The patient underwent shoulder surgery in the past and has had chronic neck pain and radicular symptoms, failing extensive conservative treatment including medications and injections as well as physical therapy. Surgery has been recommended. Pre-surgical screening has been requested but denied because the patient underwent a psychological screening six months prior for a pain management program that was denied.

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

This psychological screening is really geared at the appropriateness of this patient for surgery and not really for a multidisciplinary chronic pain program. Therefore, the findings would probably be different based on the patient's current psychological state. It would be prudent to obtain this sort of evaluation prior to

surgery, as without it, surgery could not be requested or fairly denied. Therefore, the request is clearly medically reasonable and necessary and fits the ODG Guidelines.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 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.)