



## Medwork Independent Review

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*NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION*  
*Workers' Compensation Health Care Non-network (WC)*  
*MEDWORK INDEPENDENT REVIEW WC DECISION*

**DATE OF REVIEW: 09/21/2010**

**IRO CASE #:**

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

Initial psychological testing (96103 x2 MMPI, MBMD, BDI, BDA)

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Texas Dept of Insurance Assignment to Medwork 09/02/2010
2. Notice of assignment to URA 09/02/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 09/01/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 08/31/2010
6. AR-CMI summary 09/03/2010, Novare letter 08/24/2010, 08/10/2010, medical note 08/31/2010, peer review 08/23/2010, note 08/20/2010, 08/19/2010, 08/18/2010, 08/16/2010, 08/11/2010, 08/06/2010, 08/05/2010, 08/02/2010, 07/29/2010, 07/26/2010, 07/23/2010, 07/22/2010, 07/20/2010, 07/19/2010, 07/15/2010, 07/01/2010, 06/29/2010, 06/17/2010, 06/10/2010, 06/04/2010, 05/25/2010, 05/24/2010, 05/21/2010, 05/19/2010, 05/17/2010, 05/14/2010, 05/13/2010, 05/12/2010, 05/06/2010, 04/08/2010, 04/06/2010, medicals 2004 – 2006, TDI forms 2004 - 2010
7. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

Patient is a who is status post injury to the low back on xx/xx/xx. Patient had a bilateral lumbar sprain/strain with crushing injury of the hip and shoulder region tendon when tripped and fell over a jack. Claimant still has complaint of low back pain that radiates into the legs. On physical examination there is tenderness with spasm with a negative straight leg. Patient is on multiple medications consisting of Ultracet, Lyrica, Advil, and Ambien. MRI shows a disk protrusion at L5-S1. Patient has had a functional capacity evaluation, and was deemed to be a



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good candidate for a pain management program. Patient has depression and anxiety symptoms, and has severe functional deficits according to the functional capacity evaluation. Request is for initial psychological testing (96103 x2 MMPI, MBMD, BDI, BDA).

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

Referring to the Official Disability Guidelines chapter on pain, under criteria for the general use of multidisciplinary pain programs, it states that the patient should have a thorough evaluation with a multidisciplinary group including a baseline functional and psychological testing. After review of the Official Disability Guidelines, the records reviewed are supportive to the requested initial psychological testing (96103 x2 MMPI, MBMD, BDI, BDA); therefore, the insurer's decision to uphold the request is overturned.

### **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)