Notice of Independent Review Decision

DATE OF REVIEW: 07/26/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Psychiatric Diagnostic Interview

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

Board Certified in Physical Medicine and Rehabilitation

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.

Psychiatric Diagnostic Interview – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Occupational Medicine Consult, M.D., 08/26/09
- Psychological Evaluation, Ph.D., 08/26/09

- Pain Management Functional Capacity Evaluation (FCE), P.T., 08/26/09
- Successful Returns Daily SOAP Note, Rehabilitation Centers, 08/26/09
- Pain Management Physical Therapy Plan of Care, Ms. 08/28/09
- Initial Diagnostic Screening, M.S., L.P.C., 05/01/10
- Treatment Progress Note, Ms., 07/07/10, 08/04/10
- Evaluation, M.D., 02/09/11, 05/18/11
- Mental Health Evaluation/Treatment Request, Dr. 05/26/11
- Pre-Authorization, D.O., 05/27/11
- Denial Letter, 05/27/11, 06/09/11, 06/24/11, 06/28/11
- Pre-Authorization, D.O., 06/09/11
- Response to Denial Letter, Ms. 06/09/11
- Pre-Authorization, Behavioral Health Associates, 06/23/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient had complaints of chronic lower back pain that radiated to the lower extremity. An MRI of the lumbar spine showed "ruptured" discs and "nerve damage". A surgical fusion was performed of L4-L5 and L5-S1. The fusion failed and the patient's symptoms worsened. Hardware was added and the fusion was stabilized through a second surgery. Extensive therapy programs followed and several injections were provided with minimal short-lived benefits. The patient was taking Mobic and Neurontin, as well as numerous medications prescribed by the VA. X-rays obtained in February of 2011, compared to films from March 2010, showed continued degenerative disc disease with osteoarthritic changes throughout the lumbar spine. There was a fusion at L2-L3, which appeared to be consolidated and stable. There was no spondylolisthesis noted. The discectomy at L5-S1 did not fuse, nor did the discectomy at L4-L5, but again virtually unchanged from the x-rays from 2010. It was felt the patient should undergo an anterior column arthrodesis of L4-L5 and L5-S1 with posterior transpedicular hardware placed. The patient had undergone pre-surgical evaluation and six sessions of individual psychotherapy.

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

The proposed psychiatric diagnostic interview does not appear to be reasonable and necessary. The Official Disability Guidelines requires a pre-surgical psychological screening; this has already been accomplished and has been re-requested as the previous screening is over one year old. The records do not reveal evidence to suggest any change in the patient's psychological status, so a repeat evaluation is not reasonable and necessary, nor is it supported by the ODG.

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)**

☐ **AMA GUIDES 5TH EDITION**