



## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 05/04/11

**IRO CASE #:**

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

Repeat Psychological Interview x 1 Hour  
Psychological Testing x 2 Hours

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Employer's First Report of Injury or Illness, 04/24/08
- Evaluation, Unknown Provider, 04/24/08, 04/30/08, 05/07/08, 05/18/08

- DWC Form 73, M.D., 04/24/08, 05/07/08, 05/18/08
- Radiology Report, M.D., 04/25/08
- DWC Form 73, M.D., 04/30/08
- Bona Fide Job Offer, 05/01/08, 05/08/08
- Initial Evaluation, City Therapy, 05/06/08
- Therapy, City Therapy, 05/06/08, 05/14/08
- Initial Evaluation, M.D., Ph.D., 07/17/08
- DWC Form 73, Dr. 07/17/08, 08/08/08, 09/26/08, 10/30/08, 11/13/08, 12/18/08, 01/29/09, 05/07/09, 05/28/09, 06/18/09, 07/02/09, 08/09/09, 10/01/09, 10/22/09, 12/03/09, 01/07/10, 02/04/10, 03/01/10, 04/01/10, 04/29/10, 05/28/10, 06/25/10, 07/23/10, 08/20/10, 10/01/10, 11/05/10, 12/03/10, 01/13/11, 02/10/11, 03/11/11
- Lumbar MRI, M.D., 08/04/08
- Follow Up Evaluation, Dr. 08/08/08, 08/29/08, 09/26/08, 10/30/08, 11/13/08, 01/29/09, 05/07/09, 05/28/09, 06/18/09, 07/02/09, 08/06/09, 09/10/09, 10/01/09, 10/22/09, 12/03/09, 01/07/10, 02/04/10, 03/01/10, 04/01/10, 04/29/10, 05/28/10, 06/25/10, 07/23/10, 08/20/10, 10/01/10, 11/05/10, 12/03/10, 01/13/11, 02/10/11, 03/11/11, 04/14/11
- Initial Evaluation, D.C., 08/11/08
- Electrodiagnostic Studies of the Lower Extremities, M.D., 09/03/08
- Follow Up Evaluation, Dr., 10/30/08, 11/13/08, 12/18/08, 12/22/08, 05/04/09, 08/12/09, 09/10/09, 01/13/11
- Prescription for Monthly Accessories, Dr. 12/05/08
- Designated Doctor Evaluation (DDE), M.D., 01/08/09
- Prescription and Statement of Medical Necessity, Dr. 01/23/09, 02/19/09
- DDE, M.D., 04/09/09
- Pain Management Follow Up Note, M.D., 08/19/09, 11/11/09
- Evaluation, M.D., 01/08/10, 02/08/10
- Prescription Form/Certificate of Medical Necessity, Dr. 03/25/10
- Impairment Rating, Dr. 06/04/10
- Mental Health Evaluation, Pain and Recovery Clinic 01/31/11
- Correspondence, Dr. 02/10/11
- Pre-Authorization Request, Dr. 02/24/11, 03/24/11
- Denial Letter, 03/09/11, 03/31/11
- Request for IRO, Dr. 04/07/11
- The ODG Guidelines were not provided by the carrier or the URA.

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient was injured when she slipped on the floor. She initially sought treatment, where x-rays were performed and she was treated conservatively with medications. Her condition continued to worsen and the patient underwent diagnostic studies including x-rays, MRIs and an EMG/NCV study. The claimant continued with conservative treatment, including home exercise and medications, which were reported to be Norco, Motrin and Citalopram.

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

It is my medical opinion that the requested psychological interview and testing are neither reasonable or necessary. This is an injury that occurred as an exacerbation of pre-existing pathology over three years ago. The patient has a long-standing history of medical care outside of the Workers' Compensation system including psychologic and psychiatric care. The MMPI has been requested to clarify a previously performed psychologic evaluation in an effort to qualify the patient for a functional restoration type chronic pain management program. Case testing is not necessary to qualify the patient for such a program, and in my opinion, is both unreasonable and unnecessary per the requirements of the ODG. Furthermore, this is being done only in conjunction with recommendations for a chronic pain management program, and the treating physician, Dr. in his most recent evaluation of the patient, reiterated that the patient has been released to work with restrictions and further indicated, "She is not keen on returning to any gainful employment at this time." As such, the psychological interview and testing process, in order to provide the patient with a functional restoration program, in my medical opinion is rendered invalid by ODG criteria.

**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 5<sup>TH</sup> EDITION**