

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/07/2011

**IRO CASE #:**

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

1 Psychosocial screening

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

M.D., Board Certified Neurological Surgeon

**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**

Official Disability Guidelines-Treatment for Workers' Compensation

Clinic notes first visit / injury 11/05/09

Office notes Dr. 11/10/09-07/06/10

MRI lumbar spine 12/30/09

Peer review Dr. 01/13/10

X-rays lumbar spine intraoperative 01/14/10

Operative report right lumbar laminectomy partial facetectomy L5-S1 with removal of disc fragments 01/14/10

Pathology report bone and tissue 01/14/10

Independent medical evaluation Dr. 06/22/10

Initial consultation Dr. 07/12/10

Designated doctor evaluation Dr. 08/04/10

Orthopedic consult Dr. 09/10/10-10/07/11

Behavioral evaluation report 09/29/10

Designated doctor evaluation Dr. 11/03/10

Upper GI examination 12/17/10

Peer review Dr. 02/21/11

Manual muscle testing and range of motion 05/10/11

Preauthorization review 06/06/11 regarding non-certification MRI lumbar spine

Required medical examination Dr. 06/29/11

MRI lumbar spine 09/09/11

Preauthorization determination 10/04/11 regarding non-certification medical necessity psychosocial screening

Preauthorization determination 10/17/11 regarding non-certification reconsideration psychosocial screening

Reference materials "Assessment of Psychosocial Risk Factors for Medical Treatment: A Collaborative Approach" Bruns, Disorbia published online 02/10/09

#### **PATIENT CLINICAL HISTORY SUMMARY**

This is a female whose date of injury is xx/xx/xx. She sustained a lifting / twisting injury while placing a brief case into over-head bin. She complains of low back pain with intermittent pain radiating to left lower extremity. She underwent designated doctor evaluation on 11/03/10 and was determined to have reached maximum medical improvement as of that date with 0% impairment rating. She subsequently underwent required medical evaluation by Dr. on 07/29/11. Dr. determined that further medical care that would be reasonable and necessary included aggressive home exercise program and weight loss program. She continued to complain of persistent low back pain.

MRI of lumbar spine performed on 09/09/11 revealed L5-S1 degenerative disc disease with marked disc space narrowing and 4 mm right paracentral to lateral recurrent disc protrusion. Some peripheral enhancement was evident on sagittal images, but appearance is felt to be that of recurrent disc herniation on right. The claimant was seen in follow-up on 09/23/11 by Dr. who noted the MRI on 09/09/11 revealed right laminectomy changes with evidence of recurrent disc herniation on the right at L5-S1. She remained highly symptomatic. She had residual axial back pain with some radicular type symptoms in both lower extremities right greater than left. Surgical intervention for lumbar spine was being considered, and so psychosocial screening prior to proceeding with surgical intervention was advised.

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

This patient underwent lumbar laminectomy on right at L5-S1 on 01/14/10. She continued to complain of low back pain. She underwent multiple independent evaluations including designated doctor evaluation that determined the patient reached maximum medical improvement as of 11/03/10 with 0% impairment rating. She subsequently underwent MRI of the lumbar spine on 09/09/11, which revealed postoperative changes and degenerative disc disease at L5-S1 with marked disc narrowing and 4 mm right paracentral to lateral recurrent disc protrusion. The patient was reportedly being considered for possible lumbar discectomy and fusion for chronic low back pain. However, there is no indication the patient meets criteria for spinal fusion, as there is no evidence of instability of lumbar spine, and no evidence of multiple surgical procedures at same disc level that might support the need for fusion upon third discectomy at same level. It is also noted the patient previously underwent behavioral evaluation on 09/29/10 and was determined to be an appropriate surgical candidate. There is no documentation of significant change in patient's behavioral or psychological presentation that would necessitate repeat psychosocial screening. The reviewer finds there is not a medical necessity for 1 Psychosocial screening.

**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)