

C-IRO Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/02/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat diagnostic interview (90801 x 1) and psychological testing (96100 x 3) to determine a impairment rating

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

M.D., Board Certified Psychiatry

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 medical necessity exists for each health care service in dispute. The reviewer finds that medical necessity does not exist for Repeat diagnostic interview (90801 x 1) and psychological testing (96100 x 3) to determine a impairment rating.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 06/29/12, 07/10/12

Initial comprehensive evaluation dated 03/08/12,

Behavioral health preauthorization request dated 06/27/12

Reconsideration request dated 07/06/12

Patient face sheet no date

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as a motor vehicle accident. The patient was a back seat passenger of a vehicle that slipped and spun into a ditch, hitting a large dirt mound. The tires on the vehicle popped during the accident. The patient complained of neck, upper back, rib and low back pain. Initial comprehensive evaluation dated 03/08/12 indicates that assessment is neuralgia, neuritis and radiculitis, unspecified; cervical disc displacement/herniation; displacement of lumbar and thoracic intervertebral disc without myelopathy; closed fracture of rib(s), unspecified; contusion of chest wall. The patient was noted to be in an acute care program consisting of kinetic mobilization therapy, manual therapy and therapeutic exercise. Preauthorization request dated 06/27/12 indicates that the request for diagnostic interview and psychological testing is to establish a mental health impairment rating.

Initial request for repeat diagnostic interview and psychological testing was non-certified on 06/29/12 noting that the patient underwent most recent evaluation on 03/08/12, less than 6 months ago. Therefore, medical necessity is not established at this time. Appeal letter dated 07/06/12 indicates that the alleged psychological evaluation of March 2012 did not address

the current clinical question about the psychological impairment rating. The denial was upheld on appeal dated 07/10/12 noting that ODG does not support the use of psychological testing for the purpose of determining a psychological impairment rating. The patient underwent previous psychological evaluation on 03/08/12. Dr. stated that he was not aware that a psychological evaluation had been completed and he had no information concerning the results of this evaluation. Since the patient has previously had a psychological evaluation on 03/08/12, the need for a repeat diagnostic interview and additional psychological testing could not be established.

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

The initial psychological evaluation is not submitted for review, and the results are unknown. There is no comprehensive assessment of psychological treatment completed to date or the patient's response thereto submitted for review. There is no clear rationale provided to support the request at this time. The Official Disability Guidelines do not support the use of psychological testing for the purpose of determining a patient's psychological impairment rating. The reviewer finds that medical necessity does not exist for Repeat diagnostic interview (90801 x 1) and psychological testing (96100 x 3) to determine a impairment rating.

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)