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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Psychiatric Diagnostic Evaluation

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 09/18/13, 10/16/13
Reconsideration request dated 09/25/13
Initial behavioral medicine consultation dated 12/02/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. Initial behavioral medicine consultation dated 12/02/11 indicates that the patient went to open the oven door when she felt a ripping pain in her shoulder and neck. Treatment to date includes x-rays, MRI scans, anterior cervical discectomy and osteophyctomy at C4-5 and C5-6 on 05/26/11, and physical therapy. BDI is 21 and BAI is 21. FABQ-W is 42 and FABQ-PA is 5. Diagnoses are pain disorder associated with both psychological factors and a general medical condition and major depressive disorder moderate.

Initial request for psychiatric diagnostic evaluation was non-certified on 09/18/13 noting that the patient has completed 160 hours of chronic pain management program, which is heavily oriented towards psychological intervention, and was worse. This indicates that psychological intervention is ineffective for this patient. In addition, frustration over denied treatment, especially when the denials have been at the IRO level, is not a valid rationale for psychological assessment. Reconsideration request dated 09/28/13 indicates that the last psychological evaluation as prior to the chronic pain program. The denial was upheld on appeal dated 10/16/13 noting that no additional information was provided to justify the

request, and there is no valid rationale for a repeated psychological assessment.

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

The patient sustained injuries on xx/xx/xx and has undergone treatment to include 160 hours of chronic pain management program. However, there are no recent treatment records available for review. There are no chronic pain management program progress notes submitted for review. The patient's discharge psychological testing measures are not provided. Therefore, there is insufficient information at this time to support the request. As such, it is the opinion of the reviewer that the request for psychiatric diagnostic evaluation is not recommended as medically necessary.

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)