



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 4/23/2013

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

D.O. Board Certified in Anesthesiology and Pain Management.

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

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	4/03/2013
Adverse Determination Letters	3/01/2013-3/21/2013
Pre-Authorization Requests Pre- Certification request	2/26/2013-3/14/2013 2/26/2013
Orthopedic Reports Treatment Reports	10/11/2012-2/12/2013 2/26/2013
Office Visit Notes	9/25/2006-5/09/2012
Stats Report	10/02/2012
Radiology Reports	11/02/2012
Medical Reports	2/27/2006-4/06/2006



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Office Visit Notes	1/26/2004-10/11/2005
Radiology Report	8/15/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work related injury on xx/xx/xx. He was employed when he fell and injured his back. Claimant developed severe back pain, and subsequently underwent back surgery on 10/24/1996. It is also noted in his surgical history that he had an I&D of an abscess and an ACDF (anterior cervical decompression fusion) of the cervical spine. Claimant presently taking Soma and Lorcet. Claimant did have an MRI of the lumbar spine on 09/01/11, and a CT myelogram on 11/02/2012 both reports were reviewed. Reports of Physical exam by his surgeon on 10/11/12, 12/11/12, 02/12/2013 were reviewed with the recommendation that the claimant has neurogenic claudication symptoms and would benefit from a revision of his lumbar Laminectomy and foraminotomy at L4-L5 and L5-S1. The request for surgery was denied by a recent IRO. is requesting a psychiatric diagnostic evaluation of this patient.

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

Per ODG references the request for psychiatric diagnostic evaluation is not medically necessary. Based on the information provided and the review of the patient's medical history, the determination of this patient being non operative seems accurate. There was no mentioning regarding any psychological complaints by the patient. Since the surgical procedure was denied by a recent IRO, and since there is no indication that the patient has been recommended for any further surgical procedures that would require a diagnostic evaluation at this time, the psychiatric diagnostic evaluation is not indicated for the patient.

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 KNOWLEDGE BASE
- AHCP- 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