

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

June/9/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Psychological testing

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. The patient reports that her left foot slipped causing her to fall. She lost consciousness at 9:30 am and reports she did not regain consciousness until approximately 6:00 pm. Behavioral medicine update dated 04/14/14 indicates that treatment to date includes physical therapy, lumbar laminectomy in 1994, anterior and lumbar decompression with posterolateral 360 fusion and pedicle screw instrumentation at L4-5, chronic pain management program in 2010, left lumbar sympathetic block on 10/20/10, spinal cord stimulator trial. Two weeks prior to the update the patient noticed an increase in left leg pain. Current medication is listed as hydrocodone-acetaminophen. Her mood was anxious and affect was constricted. BDI is 29 and BAI is 24. FABQ-W is 6 and FABQ-PA is 17. Diagnoses are somatic symptom disorder with predominant pain; and major depressive disorder, single episode with anxious distress. The patient was recommended for participation in a chronic pain management program.

Initial request for psychological testing was non-certified on 04/28/14 noting that the claimant has already attend a chronic pain management program in the past. There is insufficient reason for readmission into the same type of program. The claimant is still undergoing active care. The claimant has not worked since the date of injury and there is little reason to believe that return to work is a viable treatment goal. In a similar manner, there is no clear rationale for 3 hours of psychological testing. Reconsideration request dated 05/07/14 indicates that

the patient needs psychological test with validity scales as part of the assessment for a chronic pain management program. The denial was upheld on appeal dated 05/19/14 noting that the claimant's original date of injury was xxxx. Since then, she had a second injury in xxxx which compounded the first. It appears that the claimant is quite disabled from her pain state and has very poor functionality. In addition, there is a distinct question here of amplification of symptoms. It is highly questionable that a CPMP would be of any service in helping this patient make a better adaptation to her current pain state.

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. Treatment to date includes physical therapy, lumbar laminectomy in 1994, anterior and lumbar decompression with posterolateral 360 fusion and pedicle screw instrumentation at L4-5, chronic pain management program in 2010, left lumbar sympathetic block on 10/20/10, spinal cord stimulator trial. Psychological testing has been recommended to assess the patient for a chronic pain management program. The Official Disability Guidelines do not support reenrollment in or repetition of the same or similar rehabilitation program. Additionally, the Official Disability Guidelines do not generally recommend chronic pain management programs for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. As such, it is the opinion of the reviewer that the request for psychological testing is not recommended as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES