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Notice of Independent Review Decision

DATE OF REVIEW: 12/03/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

One hour diagnostic interview (90801), two hour mental health testing (96101),
and review of records (90885)

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

Licensed by the State of Texas in Psychology

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse
determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- X Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not
medical necessity exists for each of the health care services in dispute.

One hour diagnostic interview (90801) – Overturned
Two hour mental health testing (96101) - Overturned
Review of records (90885) - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 10/25/94 and 09/02/10
Preauthorization requests for mental health testing on 09/30/10 and 10/20/10
A letter of non-certification, according to the Official Disability Guidelines (ODG),
from Ph.D. dated 10/05/10
A response to denial letter from M.S., L.P.C. dated 10/08/10
A mental health evaluation/treatment request from Dr. dated 10/15/10
A medication list dated 10/15/10
A letter of denial for a psychological evaluation and testing, according to the
ODG, from Ph.D. dated 10/27/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 10/25/94, Dr. recommended and physical therapy. On 09/02/10, Dr. recommended a multidisciplinary chronic pain management program with weight loss and continued medications. On 09/30/10 and 10/20/10, there were preauthorization requests for mental health testing. On 10/05/10, Dr. wrote a letter of non-certification, according to the ODG, for the testing. On 10/08/10, Ms. wrote a letter of appeal for the denial. On 10/27/10, Dr. wrote a letter of denial for psychological testing and evaluation.

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

The requested evaluation (90801) and two hours of testing (96101) is reasonable and necessary; however, the review of records does not appear reasonable or necessary as this can be accomplished as part of the evaluation and testing. The patient had a medically objective, verifiable, documented injury. Given the accepted injury, delayed recovery and inability to resume her prior level of functioning, a psychological evaluation is essential per the ODG "to determine the existence of suspected psychological problems that are comorbid with chronic pain, to help to tailor treatment". The testing is also supported and the requestor is asking for the specific tests noted in the ODG, including the MMPI-2. The ODG states "psychosocial evaluations should determine if further psychosocial interventions are indicated." No determination can be made without an evaluation. Therefore, at this time, the requested one hour diagnostic interview (90801) and two hours of mental health testing (96101) would be appropriate and the previous adverse determinations should be overturned. However, the review of records (90885) would not be appropriate and the adverse determinations for this should be upheld.

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 AND KNOWLEDGE BASE
- 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)