



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 7/6/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for psychological testing – CPT code 96101.

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

Texas licensed clinical psychologist.

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 or not medical necessity exists for each of the health care services in dispute.

The previously denied request for psychological testing – CPT code 96101.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Evaluation dated 5/25/10
- Status Letter dated 5/25/10, 4/15/10.
- Physician Review dated 4/15/10.
- Chart Cove dated 4/7/10.
- Follow Up Visit dated 4/5/10, 7/9/09, 5/18/09, 3/31/09, 9/3/08, 7/7/08, 5/27/08, 4/29/08, 2/5/08, 1/22/08, 10/16/07, 9/18/07, 3/7/07, 2/12/07, 10/9/06, 7/31/06, 6/13/06, 5/1/06, 2/27/06.
- Report of Medical Evaluation dated 1/13/10.
- Lumbar Range Motion dated 1/13/10.
- Peer Review dated 3/4/09.
- MRI of the Lumbar Spine w/o contrast dated 2/5/08.

- MRI of the Lumbar Spine dated 10/16/07, 9/18/07, 6/13/06, 12/20/05.
- Texas Workers Compensation Work Status Report dated 7/30/07, 2/2/06, 11/28/05.
- Evaluation Letter dated 6/29/07, 4/4/07, 9/19/05,.
- Health Care Insurance Claim Form dated 4/11/07.
- Report of Medical Evaluation dated 4/4/07.
- Evaluation Summary- Functional Capacity Evaluation dated 10/13/06.
- MRI Lumbar Spine with and without contrast dated 7/31/06, 11/30/05.
- Radiology Report dated 4/12/06, 4/11/06.
- Operative Report dated 4/12/06.
- History & Physical Examination dated 4/12/06.
- Progress Note dated 4/4/06.
- Procedure Report dated 2/20/06.
- Required Medical Evaluation dated 2/2/06.
- New Patient Consultation dated 1/17/06.
- Report dated 12/20/05.
- Daily Progress and Procedural Notes dated 12/01/05, 11/28/05, 2/22/05.
- Initial Patient History Summary dated 9/19/05.
- Clinical Evaluation Summary dated 9/19/05

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Struck in the back with a large chain during normal course of work duties.

Diagnosis: Post Laminectomy Syndrome, Lumbar.

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

This male sustained an injury on xx/xx/xx. The mechanism of injury occurred when he was struck in the back with a large chain during a normal course of work duties. The diagnosis was post laminectomy syndrome of the lumbar spine. A mental health assessment, dated 5/10/10, reported the patient was recommended for a psychological assessment for clearance for implantation of a spinal cord stimulator or intrathecal infusion system in the management of chronic pain. It also noted the patient's mood was somewhat anxious. He had been previously treated with rest, physical therapy, chiropractic treatment, medication management, epidural steroid injections, and surgery, according to medical records. He complained of frustration with pain and physical limitations. He was recommended by psychologist, Ph.D. for a clinical interview with five hours of psychological testing to rule out a mood disorder, determine personality style, determine coping mechanisms, and explore the patient's medical dependency. Regardless of the patient's symptomology, a psychological assessment is warranted before any type of invasive procedure is performed. The implantation of a morphine pump is no exception. The standard form of treatment is an initial evaluation and then psychological assessment to obtain the patient's pain picture. The clinician will

look for “red flags” that may impede the claimant’s recovery, such as personality disorders, untreated depression or anxiety, to name a few. The ODG recommends that a psychological assessment be performed in these cases, but leaves the protocol and the number of hours needed to complete such assessment to the clinical judgment of the provider. However, given that these assessments have been performed for many years, there is some data on what is necessary for inclusion in the assessment (ODG). The assessment is quite complex and does require a great deal of time from the psychologist. The psychologist is responsible for interviewing the claimant and then devising a protocol (from ODG suggestions) that will evaluate the claimant based on a multitude of factors. The psychologist then must take all of the assessment data and make a determination as to whether the claimant warrants classification as a “good” candidate and/or whether the claimant may require some psychotherapy before or after the surgery. It is this reviewer’s clinical opinion that five (5) hours of assessment is excessive, but two (2) hours is not enough. This reviewer is proposing three (3) hours of psychological testing. However, the request is for five (5) hours of psychological testing (96101). This reviewer is partially overturning the request. Regarding psychological evaluations, the ODG states, “Recommended pre intrathecal drug delivery systems (IDDS) and spinal cord stimulator (SCS) trial. The following is a list of patients who are especially recommended for psychological evaluation pre- trial ([Doleys](#)): (a) Those who present with constant pain and report high overall levels of distress; (b) Patients’ who have a history of failure of conservative therapy; (c) Patient’s who have a history of failed surgery; (d) Patients who have significant psychological risk factors such as substance abuse, serious mood disorders, or serious personality disorders. Psychological predictors of success and/or failure of implantable treatment are still under research, and there is at least one study that has found psychological testing to be of modest value (although this was based on a cohort of patients that had been pre-screened by their surgeon). ([North, 1996](#)) Current suggestions for the evaluation include the following three pronged approach ([Prager, 2001](#)) ([Beltrutti, 2004](#)) ([Monsalve, 2000](#)): (1) A clinical interview including the following: (a) Social history including education, psychosocial stress factors, childhood history (including history of abuse), family situation and work history; (b) Comprehensive history including previous treatment (and response), psychological history; (c) History of substance abuse; (c) Attitudes towards pain and treatment, including painful behavior and moods of the patient; (e) Current emotional state; (f) Mental status exam; (g) Determination of motivation for recovery and return to work; (h) Issues related to implantation therapy. The interview should allow for measures of personality structure (both before and after the illness), environmental factors that influence pain, and personal strengths and internal resources. (2) An interview with a significant other (if approved by the patient) to confirm findings, alert for other significant information, and allow for assessment of social support. (3) Psychological testing. This supplements information provided in the clinical interview and, at the minimum, should evaluate personality style and coping ability. At least one test should contain validity scales. The current “gold standard” is the Minnesota Multiphasic Personality Inventory (MMPI, or a second version, the MMPI-2). MMPI scores of concern are findings of elevated neurotic triad scores (scales 1, 2, and 3; also defined as hypochondriasis [Hs], depression [D], and hysteria [Hy], or a Conversion V score [elevations of scales 1 and 3 at least 10 points above scale 2]). See [Minnesota multiphasic personality inventory](#) (MMPI). Other tests have included the Spielberger State-Trait Anxiety Inventory (STAI), Beck

Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Hospital Anxiety and Depression Scale (HAD), Millon Clinical Multiaxial Inventory (M-CMI-II), Symptom Checklist-90-R (SCL-90-R), Behavioral Analysis of Pain, Chronic Illness Problem Inventory (CIPI), McGill Pain Questionnaire (MPQ), Coping Strategies questionnaire (CSQ), and Pain Beliefs and Perception Inventory (PBPI).

Post-evaluation, three general categories of patients have been identified:

- Group 1: Patients with no contraindications for implantation
- Group 2: Patients who have a high likelihood of failure. Falling into this category does not mean that an implantable should not be used, but that contraindications should be treated prior to this intervention. The following are current suggested exclusionary criteria for the use of an implantable pain treatment ([Nelson, 1996](#)): (a) Active psychosis; (b) Active suicidal ideation; (c) Active homicidal ideation; (d) Untreated or poorly treated major depression or major mood disturbance.

Depression in and of itself in reaction to chronic pain does not disqualify a patient from implantable treatment, although moderately severe to severe depression should be treated prior to trial. Anxiety/panic disorder should also be stabilized; (e) Somatization disorder or other somatoform disorder involving multiple bodily complaints that are unexplained or exceed that could be explained by the physical exam; (f) Alcohol or drug dependence (including drug-seeking behavior and/or uncontrolled escalated use) See [Opioids, red flags for addiction](#); (g) Lack of appropriate social support; (h) Neurobehavioral cognitive deficits that compromise reasoning, judgment and memory. Other “red flags” include: a) unusual pain ratings (for example, the pain rating never changes from 9-10); b) unstable personality and interpersonal function; c) non-physiological signs reported on physical exam; d) unresolved compensation and litigation issues.

- Group 3: Patients who may require brief cognitive and/or behavioral intervention prior to the trial. These have also been referred to as “yellow flag” patients. The following are factors that have been found to increase the risk for a poor outcome: (a) Mild to moderate depression or anxiety; (b) Somatization disorder in the presence of medically explained pain; (c) Hypochondriasis if the focus is on something other than pain; (d) Mild to moderate impulsive or affective disorder; (e) Family distress/dysfunctional behavior; (f) Social distress/dysfunctional behavior; (g) Job distress/dysfunctional behavior. There is no good research as to what patients fall into this group. Treatment duration has been suggested according to severity of symptoms, with a general suggestion of approximately 6 sessions. Williams has suggested that this therapeutic intervention should include: a) education; b) skills training (training for a variety of cognitive and behavioral pain coping skills including relaxation training, activity pacing, pleasant activity scheduling, problem solving, and sleep hygiene); and c) an application phase to apply the above learned skills. ([Doleys](#)) ([Beltrutti, 2004](#)) ([Gybels, 1998](#)) ([Prager, 2001](#)) ([Williams, 2003](#)) ([Monsalve, 2000](#)) See also [Psychological evaluations](#) (above), plus [Spinal cord stimulators](#) (SCS) & [Intrathecal drug delivery systems](#) (IDDS) in the Pain Chapter.” This request was previously denied by reviewers, Ph.D. and, Ph.D., earlier this year. Both reviewers cited similar data as to why the request was denied. Both of them indicated that a psychological evaluation was warranted with a clinical interview (90801) but the amount of hours requested for psychological testing was excessive. Dr. and Dr. indicated that their independent reviews of the medical records concerning the patient contained no justification for five (5) hours of psychological testing. This reviewer agrees with the above reviews and believes that five (5) hours of psychological testing is excessive, given the documentation

in the medical records. There was no indication that this patient could be considered an outlier or that his symptoms were greater than what is typically reported by patients with this disorder. This reviewer's determination is that some hours should be authorized for testing this patient. The previous adverse determination is partially overturned to include 3 hours of psychological testing (96101).

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
 - Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Psychological Evaluations.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).