

SENT VIA EMAIL OR FAX ON  
Jul/21/2011

# Applied Resolutions LLC

An Independent Review Organization  
900 N. Walnut Creek Suite 100 PMB 290  
Mansfield, TX 76063  
Phone: (214) 329-9005  
Fax: (512) 853-4329  
Email: [manager@applied-resolutions.com](mailto:manager@applied-resolutions.com)

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Jul/21/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Psychological Testing (includes Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, EG, MMPI, Rorschach, WAIS), per hour of Psychologists or Phys.

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
M.D., Board Certified Physical Medicine Rehabilitation / 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**

OD Guidelines

1. Utilization review determination notification 06/09/11 regarding non-certification psychological testing
2. Utilization review determination notification regarding non-certification appeal request psychological testing
3. IRO referral documents
4. Preauthorization review 06/09/11
5. Preauthorization review 06/28/11
6. Preauthorization request for diagnostic interview and mental health testing
7. Office notes M.D. 02/09/11-05/28/11
8. Occupational medicine clinic consult M.D. 08/26/09
9. Psychological evaluation 08/26/09
10. Functional capacity evaluation 08/26/09
11. Preauthorization review 05/27/11 regarding non-certification lumbar decompression

and stabilization with anterior column arthrodesis at L4-5 with transpedicular fixation

12. Initial diagnostic screening / presurgical screening and treatment progress notes MS LPC 05/01/10-08/04/10

13. Response to denial letter MS LPC 06/09/11

14. Utilization review determination notification 05/27/11

#### **PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee was lifting and twisting a large pipe when he felt low back pain. His symptoms worsened over the next few days, and the patient was dragging his left foot. The patient has undergone multiple surgical procedures including L4-5, L5-S1 fusion with subsequent revision surgery for failed fusion. The injured employee was seen in follow-up by Dr. who noted the injured employee presented with low back pain with radicular signs and symptoms including incontinence and feeling of his back shifting every time he bends over. The date of last surgery was 10/08. Per Dr. note of 05/18/11, the injured employee would like to proceed with arthrodesis at L4-5 and L5-S1. He has had a psychosocial evaluation and is past that. He continues to have low back pain with numbness and penetrating pain down left leg. The injured employee was noted to have an acquired left foot drop secondary to back surgery in 2001 and left calf has atrophied. Assessment was low back pain with unstable segments of L4-5 and L5-S1 per x-rays on 02/09/11 and examination on 05/20/11. A request for surgical intervention was recommended for adverse determination. Preauthorization review dated 05/27/11 noted that at this point the injured employee had not undergone a preoperative psychological evaluation recently. He had undergone one on 05/01/10, but at that time the injured employee was not cleared for surgery. There was an indication that psychological follow up was medically necessary. There was no indication whether psychotherapy had been done or not and outcomes established. Therefore medical necessity could not be established for the proposed decompression and stabilization with anterior column arthrodesis L4-5 with transpedicular fixation.

A pre-authorization request for diagnostic interview and mental health testing was reviewed on 06/09/11 and recommended adverse determination. It was noted that there was no indication from the available documentation/information of medical necessity for repeat diagnostic/psychological testing. The injured worker was noted to have already had two previous psychological evaluations and individual psychotherapy treatment in the past and is already receiving treatment for post-traumatic stress disorder/major depression since the Vietnam War experience at an outside facility. It was further noted with diagnosis already established regarding a psychiatric condition there would be no indication to do additional psychological testing at this point. It was noted that the Official Disability Guidelines support the need to do psychological testing/evaluations but in this case the injured employee has already had these evaluations before with diagnoses established and no indication for repeat testing to be done.

An appeal pre-authorization request for psychological testing diagnostic interview and mental health testing was reviewed on 06/28/11 and it was determined that the request was not medically necessary or appropriate. It was noted that the injured employee had been followed for low back pain with radicular signs and symptoms including incontinence. The injured employee is status post lateral discectomy at L2-3 and anterior column arthrodesis at this level. The injured employee was recommended for further arthrodesis at L4-5 and L5-S1 on 03/10/11. Clinic note dated 06/09/11 states the injured employee underwent pre-surgical evaluation on 05/01/10 and was given good prognosis. The note also states he participated in six sessions of individual psychotherapy. It was determined at that time the injured employee was capable of handling a surgical intervention. The documentation states the injured employee would like to proceed with arthrodesis of L4-5 and L5-S1. The documentation submitted for review clearly states that pre-surgical evaluation and six sessions of individual psychotherapy were completed. Evidence based guidelines recommend psychological screening as an option prior to surgery, but documentation submitted states this testing has already been completed. Therefore the request for diagnostic interview is not medically necessary at this time. Since testing has already been completed the request for diagnostic interview and mental health testing is not medically

necessary at this time.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

Based on the clinical data provided, medical necessity is established for the proposed psychological testing. Request was made for one hour patient interview and two hours of testing. Records indicate the injured employee has undergone multiple surgeries. He apparently has developed a cauda equina syndrome and continues with low back pain with radicular symptoms and symptoms of incontinence. The injured employee was recommended to undergo surgery with fusion of L4-5 and L5-S1. A pre-authorization determination dated 05/27/11 non-authorized the request for surgery noting there was no current or no recent psychological evaluation. While it was noted the injured employee did undergo psychological evaluation/pre-surgical screening on 05/01/10, followed by six sessions of individual psychotherapy, the evaluation is nearly one year old. As such an updated psychological evaluation with appropriate testing is supported as medically necessary as part of the pre-operative protocol for lumbar fusion. The Official Disability Guidelines require presurgical psychological clearance to establish the patient's appropriateness for surgery and to address any potentially confounding issues.

**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)