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IRO Certificate #4599

DATE OF REVIEW: 1/26/16

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Psychiatric Diagnostic Interview (1hr) & Psychological Testing (MMP1-2-RF, MBMD, BHI-2) (4 hrs)
CPT Codes: 90791, 96101

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

Physician Board Certified in Psychiatry

REVIEW OUTCOME

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

Upheld	(Agree) <input checked="" type="checkbox"/>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

The main clinical information comes from office notes. This patient was seen as a follow up after a lumbar MRI done in XX/XXXX. He was complaining of neck pain. The pain was significantly impacting his quality of life. The patient had had previous surgeries in XXXX, lumbar spine surgery as well as a cervical procedure in XXXX. He was on medication for pain and not able to work. He was not using alcohol or drugs. No mental status issues were noted on this assessment. The conclusions were that there were herniated nucleus pulposus with back pain and radiculopathy lumbar level 2 to sacrum level 1. The plan was to do a fusion. He had reported being much better after his neck surgery and after taking several months to think over the consequences of surgery as well as the consequences of remaining on medications, he was willing to undergo surgery. He was also recommended to restart physical therapy. The services denied were a request for 1 hour of psychiatric diagnostic interview as well as 4 hrs of psychological testing. The reasons given for the denial by the insurance company reviewers included no report of results of prior pre-surgical evaluations, no report of complications from prior surgeries, and no clinical data supporting the medical necessity of the requested service. When I reviewed the appeal letter written by the requesting psychologist, the focus of that was on evaluating problems that might hinder the patient from responding well to a pain management program. However, the issue here appears to be doing these studies prior to surgery. There was no indication that the patient was planning to go to a pain management program or had psychological issues in the past or the present that might hinder his response to the pain program or would hinder him from having surgery.

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

Opinion: I agree with the benefit company's decision to deny the requested service(s).

Rationale: I am basing my opinion on the lack of documentation that there were any psychological issues present prior to this proposal to surgery. There was no plan from the doctor recommending a pain management program. What was recommended was surgery. In reviewing the Official Disability Guidelines I did not see any support for doing this kind of psychological evaluation based on the information given prior to surgery.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

Provide Description

* **Work Loss Inst., LLC, Corpus Christi; (www.odg-twc.com); Section: Mental Illness & Stress,
updated 3/14/14;**

* **Section: Low-Back Lumbar & Thoracic, Acute & Chronic: 12/02/14, 8/31/15, 9/22/15**

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)