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Notice of Independent Review Decision

DATE OF REVIEW: 8/27/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

BHI-2 Psychosocial Screening/Testing

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

Certified by the American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

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

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	722.10	96101	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician/Practitioner notes from 4/27/07 through 7/20/09

X-ray/MRI/myelogram reports dated 4/27/07, 5/11/07, 8/8/07

Operative reports dated 6/25/07, 10/1/07, 11/12/07

Nerve Conduction Study report dated 8/3/07

Computerized Muscle Testing and Range of Motion report dated 5/11/09

Functional Capacity evaluation/report 5/18/09, 5/27/09

Article-Assessments for Clinical and Psychological Use

Official Disability Guidelines provided-Low Back-Psychological screening

PATIENT CLINICAL HISTORY:

This xx-year-old female is reported to have sustained an injury to her low back as the result of lifting a furniture set on 04/26/07. The patient was evaluated on 04/27/07. The patient reported excruciating back pain radiating into the right thigh. On examination there is tenderness in the lumbar area and reduced lumbar range of motion. She has a slow gait. Knee and ankle jerks are intact. Radiographs show narrowing of the L5-S1 area. The patient was provided oral medications. She was subsequently referred for MRI of the lumbar spine on 05/11/07. This study reports evidence of a 5 mm central herniated disc causing no significant effacement of the thecal sac. There are hypertrophic changes of the facet joints bilaterally and there is no evidence of central spinal canal or foraminal stenosis.

The patient was seen on 05/24/07. At this time, the patient continues to have low back pain with radiation to the right lower extremity. She has been treated with oral medications and takes Vicodin for pain. On physical examination the patient is 61 inches tall and weighs 151 pounds. Reflexes are 2+ and symmetric. Sensation is intact. She is reported to have a positive straight leg raise. She has no evidence of weakness. Lumbar range of motion is reduced. Reflexes are 2+ at the knees and 1+ at the ankles. Radiographs are reported to indicate a grade I lytic spondylolisthesis at L5-S1 that translates 2-3 mm on flexion and extension. The patient is reported to have undergone MRI on 05/11/07 which is reported to show a grade I L5-S1 spondylolisthesis without significant HNP. The patient subsequently is to be referred for ESI. If the patient fails this she should be a candidate for posterior lumbar fusion.

The patient was seen on 06/05/07. The patient's physical examination is unchanged. Reflexes are reported to be 2+ and symmetric. The patient was recommended to get EMG of the lower extremities and undergo a right L5-S1 transforaminal ESI. On 06/25/07 the patient underwent L5-S1 transforaminal ESIs. On 08/03/07 the patient is reported to have undergone EMG/NCV study. This study reports lumbar radiculopathy involving the L5 nerve roots bilaterally, most significant in the right L5 nerve root. This appears to have been based off of nerve conduction velocities. The EMG is normal.

On 08/08/07 the patient was referred for CT myelogram of the lumbar spine. This study reports a subtle grade I spondylolisthesis at the L5-S1 level. There is no evidence of nerve root cutoffs. Post myelogram CT reports a subtle spondylolisthesis of L5 on S1 of approximately 5 mm. There are considerable degenerative changes noted in the posterior facets at L5-S1. There is no evidence of pars defect. The central canal from T12-L1 through L5-S1 demonstrates no evidence for significant central stenosis. From L1-2 through L4-5 there is no evidence for significant disc pathology. At L5-S1 there appears to be a lateral disc bulge encroaching in the inferior margin of the right foraminal recess.

On 08/14/08 the patient was evaluated and it was noted that the patient has been treated with conservative care including 1 injection. She currently has complaints of pain in the mid back, lower back, right hip, right knee, right ankle and right leg. She complains of numbness at the bottom of her foot. On examination she is pleasant and cooperative. She ambulated into the room with normal gait and posture. Straight leg raise was 70 degrees on the left and 50 degrees on the right with pain. Patrick Faber test was positive

bilaterally. Sitting root test was negative bilaterally. The patient is reported to have mildly decreased sensation on the right in the L3-S1 dermatomes. Reflexes are 2+ and symmetric. Motor strength is reported to be 3/5 in the right lower extremity. The evaluator opines that the extent of injury is limited to herniated disc at L5-S1. The degenerative disc disease, degenerative facet disease and osteoarthritic changes are not a result of the injury.

On 10/01/07 the patient underwent an S1 transforaminal ESI. She underwent further transforaminal ESIs on 11/12/07.

On 02/20/08 the patient was seen and a RME was performed. These notes indicate that the patient received some benefit from epidural steroid injections reducing her leg pain. On physical examination the patient's range of motion is reduced. There is some slight loss of the ankle reflex on the right when compared to the left. The practitioner opines that the patient sustained a soft tissue injury which was superimposed on pre existing degenerative disease and recommends a FCE allowing the patient to return to work on modified activity.

On 05/11/09 the patient was evaluated and it is reported that the patient has undergone 6 ESIs that seemed to help some of her leg symptoms. She presently complains of low back pain with radiation into the right lower extremity. On physical examination she has tenderness in the lower lumbar region with painful and decreased lumbar range of motion. Straight leg raise is reported to be positive on the right. She has some paresthesias along the right L5. Motor strength appears grossly intact and reflexes were symmetric. She was provided prescription medications. Imaging studies were requested and she was referred for FCE. The FCE dated 05/27/09 suggests that the patient is at a medium physical demand level.

On 06/03/09 the patient was placed at statutory MMI. She was opined to have 25 percent whole person impairment. The physician noted that the patient is not at clinical MMI.

On 07/16/09 the patient was seen in follow up and the patient is noted to have continued tenderness and pain in the lower lumbar region with decreased range of motion. Straight leg raise was positive on the right. She continues to have paresthesias in the right L5 dermatome. There was decreased motor strength on the right side as compared to the left. Patellar reflexes are 2+ and symmetric bilaterally. It is also noted that the patient's lumbar myelogram showed an 8.5 mm grade I spondylolisthesis at L5-S1. Flexion and extension radiographs of the patient's lumbar spine are reported to show 2.5 mm of translation between flexion and extension. No angular change was noted. The physician reports that the impression showed lumbar radiculopathy involving the L5 nerve roots bilaterally right greater than left. The patient is opined to be a possible candidate for fusion at L5-S1 to address her L5 radiculopathy on the right side. The patient was subsequently recommended to undergo pre operative psychosocial screen.

On 07/20/09 the patient was seen and it is noted that the patient is a cigarette smoker, 5'0" and 174 pounds. She is reported to be well developed and well nourished. She ambulates using a cane in the right hand. Examination noted tenderness over the paravertebral muscles bilaterally and tenderness over the sciatic notch on the right, decreased range of motion secondary to pain. Sitting root test is positive on the right in that it produces light pain out of the calf. DTRs are 1+ bilaterally and Achilles reflex is

absent on the right. Motor strength appears intact and there is questionable decreased sensation over the right foot and leg area. The physician opines that the patient has not reached clinical MMI and notes that the patient has been recommended to undergo surgery. He reports the date of statutory MMI to be 05/01/09 and assigns 10 percent whole person impairment.

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

In the Reviewer's opinion, BHI – 2 psychosocial screening/testing is medically necessary for this patient. The available medical record indicates that the patient sustained an injury to her low back as the result of work related activity on xx/xx/xx. Records indicate that the patient has been treated with oral medications, physical therapy and 6 ESIs. The patient has undergone EMG/NCV studies which are suggestive of bilateral L5 radiculopathy however it should be noted that the EMG portion was normal. The patient subsequently came under the care of another physician who has reviewed the patient's imaging studies and history of treatment and notes that the patient has not responded to conservative care and has evidence of a spondylolisthesis of L5 on S1 which is stable and only documented as having 2.5 mm of translation. This patient's current physician clearly intends to request operative intervention on this patient and per ODG guidelines, pre operative psychiatric evaluation is required to address any potentially confounding issues which may impact the patient's surgery. This information is required in order to submit the surgical request. Therefore, based upon the ODG guidelines, the request for BHI-2 psychosocial screening/testing would be considered medically necessary and appropriate given the totality of the clinical information.

References:

The 2009 Official Disability Guidelines, 14th edition, The Work Loss Data Institute. Online edition.

Low Back Chapter: Psychological screening

Recommended as an option prior to surgery, or in cases with expectations of delayed recovery. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as MMPI (Minnesota Multiphasic Personality Inventory) and Waddell signs. ([Scalzitti, 1997](#)) ([Fritz, 2000](#)) ([Gaines, 1999](#)) ([Gatchel, 1995](#)) ([McIntosh, 2000](#)) ([Polatin, 1997](#)) ([Riley, 1995](#)) ([Block, 2001](#)) ([Airaksinen, 2006](#)) A recent study concluded that psychological distress is a more reliable predictor of back pain than most diagnostic tests. ([Carragee, 2004](#)) The new ACP/APS guideline as compared to the old AHCPR guideline is a bit stronger on emphasizing the need for psychosocial assessment to help predict potentially delayed recovery. ([Shekelle, 2008](#)) For more information, see the [Pain Chapter](#) and the [Stress/Mental Chapter](#).

ODG Indications for Surgery™ -- Discectomy/laminectomy --

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383. ([Andersson, 2000](#)) Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
 1. Severe unilateral quadriceps weakness/mild atrophy
 2. Mild-to-moderate unilateral quadriceps weakness
 3. Unilateral hip/thigh/knee pain
 - B. L4 nerve root compression, requiring ONE of the following:
 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
 3. Unilateral hip/thigh/knee/medial pain
 - C. L5 nerve root compression, requiring ONE of the following:
 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 3. Unilateral hip/lateral thigh/knee pain
 - D. S1 nerve root compression, requiring ONE of the following:
 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 3. Unilateral buttock/posterior thigh/calf pain
- (EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)
- II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:
- A. Nerve root compression (L3, L4, L5, or S1)
 - B. Lateral disc rupture
 - C. Lateral recess stenosis
- Diagnostic imaging modalities, requiring ONE of the following:
- 1. [MR](#) imaging
 - 2. [CT](#) scanning
 - 3. [Myelography](#)
 - 4. [CT myelography](#) & X-Ray
- III. Conservative Treatments, requiring ALL of the following:
- A. [Activity modification](#) (not bed rest) after [patient education](#) (≥ 2 months)
 - B. Drug therapy, requiring at least ONE of the following:
 1. [NSAID](#) drug therapy
 2. Other analgesic therapy
 3. [Muscle relaxants](#)
 4. [Epidural Steroid Injection](#) (ESI)
 - C. Support provider referral, requiring at least ONE of the following (in order of priority):
 1. [Physical therapy](#) (teach home exercise/stretching)
 2. [Manual therapy](#) (chiropractor or massage therapist)
 3. [Psychological screening](#) that could affect surgical outcome
 4. [Back school](#) ([Fisher, 2004](#))

Fusion:

Fusion (spinal)

Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-

myelogram, or discography (see discography criteria) & MRI demonstrating disc pathology; & (4) Spine pathology limited to two levels; & (5) Psychosocial screen with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (Colorado, 2001) (BlueCross BlueShield, 2002)

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 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)