

# Becket Systems

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/12/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpatient additional psychological testing to include BHI-2 and MBMD as it relates to the lumbar area

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

Clinical Psychologist  
Member of the American Academy of 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**

Adverse Determination Letters, 1/7/09, 1/30/09  
ODG Guidelines and Treatment Guidelines  
2/26/09, 1/23/09, 12/12/08, Addendum to 12/12/08  
DO, 1/12/09, 12/15/08, 11/26/08  
MD, 8/30/05, 2/16/05  
MRI, 9/10/04  
Radiology, 7/27/05  
Medical Clinic, 8/2/04, 8/6/04, 9/7/04, 1/6/05, 3/21/05, 12/15/05, 8/25/06  
PT Notes, 8/17/04-10/14/04, 11/18/04  
MD, 10/12/04, 11/29/04, 5/9/05, 6/18/05, 6/20/05  
Lumbar ESI, 6/8/05, 7/27/05

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who was injured while at work on xx/xx/xx. At the time, he was performing his usual job duties. On the above mentioned date, he injured his back when he attempted to lift a bag of industrial sized mop heads, and reports feeling immediate pain in his back. He was taken off work at the time, but has since returned to full duty work with the

same employer. He apparently was out of the medical/work comp system for a period of time, but has recently re-engaged for follow-up with his case.

Claimant has received the following diagnostics and treatments to date: x-rays, MRI, active and passive physical therapy, injections x 3, and medications management. MRI done in 2004 showed postoperative changes at L4-L5 and a new central disk herniation at L3-L4. DD exam conducted 8-30-05 placed him at MMI with a 5% impairment rating. At the time, reports stated "examinee complains of constant pain across the lower back and down the legs with numbness in the toes on the left foot. The pain is most severe with physical activity and prolonged sitting or standing. Getting off feet and raising the legs reduce the pain. The examinee rates his current pain level and average daily pain level at 4/10...The examinee is doing well. He is improved and although not asymptomatic, he does not want to have surgery."

On 12-12-08, patient was interviewed and evaluated by LPC, in order to assess patient's suitability for "some level of behavioral health care, secondary to persistent pain and adjustment issues." Patient was administered the BDI and BAI, interviewed, and given a mental status exam. Current pain level is rated as 5/10 and pain is described as aching pain to the low back region. Patient is currently working without restrictions. Medications include Clonidine, Cardizem, and Rampiril.

Patient reported sleeping 6-7 fragmented hours per night. BDI was a 4 and BAI was 1, both within normal limits. Mental status was good. Patient reported his overall functioning prior to 2004 injury as 80%, and current post-injury functioning as 70%. He rated his perceived level of: interference due to pain as 4/10, irritability and restlessness as 7/10, frustration/anger as 3/10, muscle tension/spasms as 9/10, nervousness/worry as 3/10, sadness/depression as 1/10, sleep disturbance as 4/10 and forgetfulness as 2/10. Patient was diagnosed with R/O 307.89, Pain Disorder, and request was made for 4 hours of testing to include BHI-2 and MBMD.

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

The ODG states that initial evaluations should "focus on identifying possible red flags or warning signs for potentially serious psychopathology that would require immediate specialty referral. Red flags may include impairment of mental functions, overwhelming symptoms, signs of substance abuse, or debilitating depression. In the absence of red flags, the occupational or primary care physician can handle most common stress-related conditions safely."

Based upon the medical records provided for this review, this does not appear to be an "appropriately identified patient" per ODG. Likewise, there is no indication that the patient perceives himself as needing psychological or behavioral intervention at this time. He has worked at his current employment for over 25 years, and it does not appear that his current behavioral status is threatening to interfere with any significant aspect of his life, impeding any efforts at rehabilitation, or is increasing his pain level over and above what is due to the physical pathology. The reviewer finds that medical necessity does not exist for Outpatient additional psychological testing to include BHI-2 and MBMD as it relates to the lumbar area.

Psychological Screening; Low Back Chapter 2009: 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.

Psychological Screening; Pain Chapter 2009: Recommended based upon a clinical impression of psychological condition that impacts recovery, participation in rehabilitation, or prior to specified interventions (e.g., lumbar spine fusion, spinal cord stimulator, implantable drug-delivery systems). (Doleys, 2003) Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003)

Comorbid psychiatric disorders: Recommend screening for psychiatric disorders. Comorbid psychiatric disorders commonly occur in chronic pain patients. In a study of chronic disabling occupational spinal disorders in a large tertiary referral center, the overall prevalence of psychiatric disorders was 65% (not including pain disorder) compared to 15% in the general population. These included major depressive disorder (56%), substance abuse disorder (14%), anxiety disorders (11%), and axis II personality disorders (70%). (Dersh, 2006) When examined more specifically in an earlier study, results showed that 83% of major depression cases and 90% of opioid abuse cases developed after the musculoskeletal injury. On the other hand, 74% of substance abuse disorders and most anxiety disorders developed before the injury. This topic was also studied using the National Comorbidity Survey Replication (NCS-R), a national face-to-face household survey. (Dersh, 2002) See also Psychological evaluations.

Psychological treatment: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested

Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention

Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.

Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines for low back problems. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005)

**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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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