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Notice of Independent Review Decision

DATE OF REVIEW: October 11, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Diagnostic psychological interview – lumbar 90801

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

Clinical Psychologist

Member American Academy of Pain Management

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI:

- Utilization reviews (08/16/10 – 08/25/10)

Dr. :

- Office visits (07/09/10 – 08/04/10)
- Utilization reviews (08/16/10 – 08/25/10)

Law Office of:

- Carrier Submission (09/29/10)

:

- Office visits (03/16/10 - 08/18/10)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was making dough for tortillas in a. He lifted it and as he turned to place it down, he heard a popping sound in his back with sharp pain in the low back that began to radiate down the right leg.

2006 – 2007: From 2006 through 2007, the patient was seen by, D.C., M.D., M.D. and M.D. orthopedic surgeons and M.D., a pain management physician. He was also seen at Hospital and Medical Center emergency rooms (ER). The patient re-injured his back when he lifted a 25-lb object and felt dizzy, lightheaded and short of breath and vomited due to the severity of pain. He complained of low back pain radiating down the right leg, pain in the posterior calf area on the right side and bottom of the right foot, weakness of the right foot muscle and difficulty sleeping. Examination revealed tenderness in the lower lumbar region, significant muscle spasm extending from the mid-thoracic to the lumbosacral borders bilaterally, swelling, dyskinesia in the motor units in the lumbar spine, excruciating tenderness to the right lumbosacral border, inability to heel and toe walk, increased muscle tone, midline tenderness over the L5-S1 areas, right sciatic notch and posterior thigh tenderness, positive tension sign on the right, weakness of the right extensor hallucis longus (EHL), hypesthesia of the right L5 and S1 dermatome, decreased range of motion (ROM) and positive straight leg raise (SLR) on the right to 30 degrees. He underwent magnetic resonance imaging (MRI) of the lumbar spine that revealed a 3-mm annular disc bulge at L3-L4 with flattening the thecal sac and mild bilateral foraminal narrowing; 8-mm right subarticular disc extrusion at L4-L5 and free fragment dissecting into the lateral recess of L5 compressing the right L5 nerve root and moderate bilateral foraminal narrowing and degenerative disc disease (DDD) with annular disc bulge at L5-S1. Electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities showed lumbosacral radiculopathy at the L5 nerve root with active denervation in the L5 distribution. X-rays of the lumbar spine revealed multilevel degenerative bony changes and mild disc space narrowing at L4-L5 and L5-S1. The patient was diagnosed with lumbar intervertebral disc syndrome with radiculopathy into the right leg, lumbar intersegmental dysfunction syndrome, lumbar myofascitis and L4-L5 disc herniation with sequestered fragment and right radiculopathy. He was initially treated with medications and chiropractic modalities and eventually underwent a right L4-L5 laminotomy, discectomy and foraminotomy in October 2006.

In 2007, the patient complained of persistent low back pain with severe radiation of pain into the left lower extremity and inguinal area, numbness of the lateral three toes of the right foot. Examination showed moderately severe left-sided lumbosacral tenderness, muscle spasms from the lower thoracic to the lumbosacral borders bilaterally, SLR producing perceived low back pain and posterior hamstring pain on the left, decreased plantar flexion on the left, decreased sensation along the right L4-L5 and S1 dermatomes, tenderness at the left facets from L4 to S1, mild-to-moderate myofascial and trigger point tenderness to the bilateral lumbosacral regions most notably to the paravertebral regions of the lumbosacral spine, tenderness of the right sacroiliac (SI) joint and mild decrease in sensation to the right lower extremity. EMG/NCV of the lower extremities showed active lumbosacral radiculopathy at the L5 and S1 nerve root levels. The patient underwent functional capacity evaluation (FCE) x2 and was determined to be a good candidate for work conditioning program (WHP).

In July, M.D., a designated doctor, opined the patient was not at maximum medical improvement (MMI) and recommended ESI.

In September 2007, he underwent psychological evaluation and was diagnosed with adjustment disorder with mixed emotional features, pain disorder associated with psychological factors and general medical condition. The evaluator assessed chronic pain syndrome secondary to the work-related injury. The patient was experiencing psychological distress in the form of reactive anxiety and depression secondary to his injury and was recommended interdisciplinary pain management program. Other diagnoses were displaced lumbar intervertebral disc, lumbar postlaminectomy syndrome and right L4-L5 recurrent disc herniation with right radiculopathy. He was treated with medications, flexion-distraction adjustments, epidural steroid injection (ESI) and eventually a right wide L4-L5 laminotomy, discectomy, cicatrix removal and foraminotomy in October 2007.

2008: Mr. reported low back pain radiating down the right leg associated with numbness and tingling in the right lower extremity, cramping and weakness of the right leg and ankle. Dr. and Dr. treated him with medications (hydrocodone, Zanaflex, Lortab, Elavil, compound #10 gel, Ultram ER) and various durable medical equipment (DME). Dr. provided interferential therapy.

Dr. placed the patient at clinical MMI as of March 27, 2008, with 10% whole person impairment (WPI) rating.

In an initial psychological evaluation (6/16/08), the patient was noted to be experiencing psychological distress in the form of depression, anxiety and irritability secondary to his work-related injury. The evaluator recommended individual psychological services.

MRI of the lumbar spine revealed: (1) At L3-L4, an annular disc bulge flattening the thecal sac with mild narrowing of the left neuroforamen. (2) At L4-L5, there was a residual annular disc bulge, enhancement of discectomy site as well as the laminectomy site. Postoperative scar encased the right L5 nerve root sleeve. Mild bilateral foraminal stenosis was seen. (3) At L5-S1, there was an annular disc bulge noted.

In a required medical evaluation (RME), D.O., rendered the following opinions: (1) The complaints were causally related to the original compensable injury. (2) With the exception of the pharmaceutical use, the treatment appeared to be roughly in line and TENS unit was not reasonable. (3) Ongoing prescription medications were not reasonable. (4) He required ongoing supportive care in the form of appropriate medications, good HEP and office visits once every four to six months. (5) The effects of the injury had resolved with some residual radicular type symptoms.

2009: Dr. treated the patient with Skelaxin, Darvocet N and Celebrex while Dr. treated the patient with hydrocodone, Flexeril, Lyrica and Celebrex.

Dr. rendered the following opinions: (1) Hydrocodone and Flexeril were not in line with the ODG. A tricyclic antidepressant should be prescribed. (2) Further treatment included use of appropriate medications, a repeat MRI and a selective

nerve root block. Additional procedures such as surgery would be indicated after the results of imaging studies.

MRI of the lumbar spine revealed: (1) At L3-L4, there was an annular disc bulge flattening the thecal sac with bilateral facet joint arthrosis and mild bilateral foraminal narrowing. (2) At L4-L5, there was a right-sided laminectomy and discectomy, a residual 4.0 mm right subarticular disc protrusion abutting the right L5 nerve root sleeve as well as adjacent thecal sac. Postoperative scar surrounded the right L5 nerve root sleeve and there was moderate narrowing of the right with mild narrowing of the left neuroforamen. (3) At L5-S1, there was an annular disc bulge.

2010: Dr. treated the patient with medications including hydrocodone, Lyrica, Elavil and Soma.

In an addendum, Dr. opined as follows: (1) An ESI would be beneficial and fusion procedure was not necessary. (2) If the ESI failed then it would not be unreasonable to consider a decompression procedure.

Dr. recommended an L4-L5 discogram followed by decompressive laminectomy at L4-L5, TLIF and posterolateral arthrodesis of L4-L5 with pedicle stabilization.

Dr. issued a prescription for psychological evaluation because Dr. felt that a lumbar fusion would be needed.

M.D., recommended proceeding with a discogram at the L4-L5 level.

On June 18, 2010, M.D., performed a right L4 transforaminal ESI.

Dr. noted the legs had become progressively weak following the injection. There was progressive right lower extremity weakness. Hydrocodone and Soma were refilled and a discogram was recommended.

Dr. noted no relief following the ESI. He recommended a psychiatric evaluation to see if there were any psychological barriers preventing him from benefiting from a spinal arthrodesis.

M.A., LPCS, requested a repeat diagnostic interview (pre-surgical evaluation).

M.D., denied the repeat diagnostic psychological interview based on the following rationale: *"The patient has chronic back pain and it seems that the surgeon is contemplating on L4-L5 decompressive laminectomy and lumbar fusion as per note dated March 16, 2010. The patient has received lumbar ESI without much benefit. Recent clinical information including subjective and objective data information is not available. The findings of prior psychological testing and the time elapsed since the prior screening are not known. It is also unclear if surgery has been approved. The necessity of the request is not substantiated at this time."*

On August 18, 2010, Dr. requested reconsideration for the case. About the psychological testing, after reviewing files, it was found that they had never been requested. For the last psychological evaluation that was approved on

November 13, 2008, the process could not be continued at that point due to the fact that the patient could not be contacted. The request for this mental health evaluation was to evaluate whether or not the patient was ready for the surgery.

On August 25, 2010, M.D., denied the appeal for a repeat diagnostic psychological interview based on the following rationale: *“This is an appeal of a prior denial in which the previous reviewer opined that the clinical information which included subjective and objective data was not available. The findings of prior psychological testing and the time elapsed since the prior screening was unknown. It also stated that it was unclear if the surgery had been approved. This reviewer agrees with the previous denial. While psychological evaluations are appropriate prior to surgery, there would need to be additional clinical documentation submitted for review before further consideration of this request. It is unknown given the limited clinical documentation submitted for review as to when the most recent psychological evaluation and diagnostic interview was conducted. It is also unclear as to the results of this interview. As such, this request is not certified at this time.”*

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

Patient appears to have undergone numerous invasive procedures, including past surgeries, which he overall, has not seemed to benefit from. If surgery is to be considered again, he would need to be cleared from a psychological standpoint at this time. As per ODG, a psychological screening with testing is recommended.

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

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)

Psychological Screening; Pain Chapter 2010: 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](#)) See "[Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients](#)" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI 2nd ed - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superseded by the MBMD following, which should be administered instead], (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale – VAS. ([Bruns, 2001](#)) Chronic pain may harm the brain, based on using functional magnetic resonance imaging (fMRI), whereby investigators found individuals with chronic back pain (CBP) had alterations in the functional connectivity of their cortical regions - areas of the brain that are unrelated to pain - compared with healthy controls. Conditions such as depression, anxiety, sleep disturbances, and decision-making difficulties, which affect the quality of life of chronic pain patients as much as the pain itself, may be directly related to altered brain function as a result of chronic pain. ([Baliki, 2008](#)) See also [Comorbid psychiatric disorders](#). See also the [Stress/Mental Chapter](#).

Psychological Screening; Low Back Chapter 2010: 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](#)

<p>Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators)</p>	<p>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):</p> <p>(1) <u>A clinical interview including the following:</u> (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.</p> <p>(2) <u>An interview with a significant other</u> (if approved by the patient) to confirm findings, alert for other significant information, and allow for assessment of social support.</p> <p>(3) <u>Psychological testing</u>. 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,</p>
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	<p>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).</p> <p>Post-evaluation, three general categories of patients have been identified:</p> <ul style="list-style-type: none"> - <i>Group 1</i>: Patients with no contraindications for implantation - <i>Group 2</i>: 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. <p>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.</p> <p>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.</p> <p>- <i>Group 3</i>: 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.</p>
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DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**