CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: January 7, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Diagnostic Interview and 3 Units of Psychometric Testing for Pre-Discogram Psychological Screening

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a licensed Psychologist with over 25 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
08/23/12: Consultation
11/20/12: Follow-Up
12/05/12: Peer to Peer
12/10/12: UR
12/13/12: Request for Reconsideration
12/17/12: UR
12/18/12: Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was working as a nurse when she was injured while lifting a patient that had fell. She underwent physical therapy for several months with was helpful at first. She also underwent a SNRB L5-S1 on 12/22/11 which was not helpful. It was recorded in the records that she underwent a Lumbar MRI on 09/13/11 that revealed disc bulges at L3-4, L4-5, L5-S1 and disc dessication at the L5-S1 level, with a bulge bilaterally, more so to the right. Other bulges were mild and to the left.

On August 23, 2012, the claimant was evaluated for back pain and leg pain located on the right side. The claimant was referred for surgery consult. It was reported that the claimant had not had prior surgery, had undergone an ESI that didn't help, had PT and Work Conditioning with no help. Current medications were listed as Lyrica and Norco. On physical examination her paravertebral muscles were non-tender, with no evidence of spasm or trigger point. Lumbar range of motion: flexion was painful at usual pain of normal, extension was painful at usual pain of normal, rotation on the right was non-painful, rotation on the left was non-painful, lateral bending to the right was painful at usual pain of normal, lateral bending to the left was non-painful. Spinous processes were tender at the lower region. Spinous processes comments: L5 an sacral. Straight leg raises were normal bilaterally. Lower strength was symmetrically present in all lower extremity muscle groups. Ankle was normal. Knee was normal. Light touch was normal. Plan: ESI at L5-S1 on the right.

On November 20, 2012, the claimant was re-evaluated by XXXX, MD for stable low back and pain that radiates into the proximal right hamstring and limits her physically surgically with standing, lifting, and walking. It was reported she was doing her home exercises and taking Hydrocodone 4-6 a day. On physical exam her lower paravertebral muscles were tender on the right. Lumbar range of motion was generally stiff and most painful with flexion and right side bending. Spinous processes were non-tender. Straight leg raise was normal bilaterally, but the right did aggravate her axial pain. The Fabere maneuver also created a "pulling" sensation in the axial spine. She had no gross weakness in the lower extremities. Assessment: 1. Chronic right low back pain with proximal leg radiculitis with noted right sided disc protrusion at L5-S1 following a work-related injury. 2. Obesity. Plan: 1. Lisa has had a consultation with Dr. XXXX and discussed the possibility of the decompression surgery at L5-S1. At this point however, her distal radicular symptoms have resolved and she is primarily having axial complaints. They also questioned the possibility of sacroilitis as a component. I have not seen this as a consistent issue and I believe her pain is primarily discogenic coming from L5-S1. Lisa understands that surgery for this may involve disc replacement or even fusion and that a simple decompression surging maybe inspiration. 2. Dr. XXXX had requested an epidural at L5-S1 which has been denied. Lisa tells me that her favorable hearing occurred subsequently and I think it's reasonable to request epidural. 3. I will also set her up with presurgical psychological clearance as she would likely require discography prior to surgical consideration but would require clearance even for a decompression surgery.

On December 10, 2012, XXXX, MD performed a UR. Rationale for Denial: ODG guidelines note that psychological evaluation is recommended in certain cases of chronic pain. In this case the candidacy for a lumbar fusion procedure has not been established and there is no indication that there is a planned procedure for a fusion at this time. Furthermore, psychological clearance is not required prior to discography. In the absence of clear evidence for the surgical procedure the medical necessity of the psychological clearance is not established.

On December 13, 2012, XXXX, PhD wrote a request for reconsideration. Dr. XXXX stated that the rationale for the denial was that "the necessity for the fusion decision to have been made prior to the testing." However, Dr. XXXX argued that while the claimant is clearly being evaluated as a surgical candidate, and a discogram is pending, the request for the diagnostic interview and testing was made under the ODG guidelines for "psychological evaluation in chronic pain". Thus, the need for a surgical decision is obviated. Dr. XXXX goes on to state that the claimant has a clear anxiety disorder, being on 3 mg of Xanax per day, and is taking narcotic medications. He further stated that those issues were likely to have some impact on whatever treatment she receives for her spine injury and the treating surgeon had request a psychological evaluation to assess such a concern.

On December 17, 2012, XXXX, MD performed a UR. Rationale for Denial: In the case discussion it was noted that the provider has not seen the claimant yet. The claimant was referred for the testing in order to determine if the claimant is a candidate for the discogram and fusion. As far as the provider knows these tests have not yet been ordered but the claimant has anxiety disorder and has been on narcotics. These tests will be used to determine how the anxiety disorder influences the presentation by the claimant in reporting the pain. In this case, the current documentation indicates that the claimant continues with low back pain and radiation to the proximal hamstring. The pain affects functional activities such as standing, walking, and lifting. The documentation indicates the claimant is currently having primarily axial complaints with resolution of distal leg complaints. The provider reports that an MRI was completed on 09/13/11 and noted disc bulges at L3-4, L4-5, and L5-S1. There was disc desiccation at the L5-S1 noted as well. The provider requests a psychological screening prior to discogram to determine if the claimant is a surgical candidate however ODG does not require psychology evaluation prior to discograms, only prior to fusion. ODG states that discography may be supported if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not justify fusion). Review of documentation provided does not support a plan for fusion at L5-S1 or clinical and imaging findings which support the need for fusion. The medical necessity of the request for diagnostic interview and 3 units of psychometric testing for pre-discography screening is not established.

On December 18, 2012, XXXX, PhD writes another request for reconsideration after receiving the second denial. In this letter he points out ODG guideline for discography highlighting one criteria: Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided). Dr. XXXX also points out that the request for psychological evaluation meets the ODG guideline for psychological evaluation in Chronic Pain, which was the ODG guideline under which Dr. XXXX made his submission of the request. He highlights that the guideline states: "Recommended based upon a clinical impression of psychological condition that impact recovery, participation in rehabilitation, or prior to specified interventions (e.g., lumbar spine fusion, spinal cord stimulator, implantable drug-delivery systems)." Dr. XXXX makes the final argument that it is only common sense reason to perform a psychological evaluation on a patient who consumes high doses of anxiolytic and narcotic pain medication, who is not progressing an may become a surgical candidate.

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

The previous adverse determinations are upheld. The requested service was specifically for a Diagnostic Interview and 3 Units of Psychometric Testing for Pre-Discogram Psychological Screening. Upon review of the medical documentation provided for my review, it is in my opinion that the UR performed by Dr. XXXX on December 10, 2012 was correct in concluding that there is no planned procedure for a fusion at this time and psychological clearance is not required prior to discography and in the absence of clear evidence for surgical procedure the medical necessity of the psychological clearance is not established. The UR performed by Dr. XXXX on December 17, 2012 was also correct in concluding the claimant was referred for testing in order to determine if the claimant is a candidate for the discogram and fusion, ODG does not require a psychological evaluation prior to discograms, only prior to fusion, and review of documentation provided does not support a plan for fusion at L5-S1 or clinical and imaging findings which support the need for fusion. Therefore, I find the request for Diagnostic Interview and 3 Units of Psychometric Testing for Pre-Discogram Psychological Screening not medically necessary.

PER ODG:

Under Pain Chapter:

Psychological evaluations	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 superceded 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) Maladjusted childhood behavior is associated with the likelihood of chronic widespread pain in adulthood. (Pang, 2010) Psychosocial factors may predict persistent pain after acute orthopedic trauma, according to a recent study. The early identification of those at risk of ongoing pain is of particular importance for injured workers and compensation systems. Significant independent predictors of pain outcomes were high levels of initial pain, external attributions of responsibility for the injury, and psychological distress. Pain-related work disability was also significantly predicted by poor recovery expectations, and pain severity was significantly predicted by being injured at work. (Clay, 2010) See also Comorbid psychiatric disorders. See also the Stress/Mental Chapter.

Under Lumbar Chapter:

Discography	Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion. These studies have suggested that reproduction of the patient's specific back complaints on injection of one or more discs (concordance of symptoms) is of limited diagnostic value. (Pain production was found to be common in non-back pain patients, pain reproduction was found to be inaccurate in many patients with chronic back pain and abnormal psychosocial testing, and in this latter patient type, the test itself was sometimes found to produce significant symptoms in non-back pain controls more than a year after testing.) Also, the findings of discography have not been shown to consistently correlate well with the finding of a High Intensity Zone (HIZ) on MRI. Discography may be justified if the decision has already been made to do a spinal fusion, and a negative discogram could rule out the need for fusion on that disc (but a positive discogram in itself would not allow fusion). (Carragee-*Spine*, 2000) (Carragee2-*Spine*, 2000) (Carragee3-*Spine*, 2000) (Carragee4-*Spine*, 2000) (Bigos, 1999) (ACR, 2000) (Resnick, 2002) (Madan, 2002) (Carragee-*Spine*, 2004) (Carragee2, 2004) (Maghout-Juratli, 2006) (Pneumaticos, 2006) (Airaksinen, 2006) (Manchikanti, 2009) Discography may help distinguish asymptomatic discs among morphologically abnormal discs in patients without psychosocial issues. Precise prospective categorization of discographic diagnoses may predict outcomes from treatment, surgical or otherwise. (Derby, 2005) (Derby2, 2005) (Derby, 1999) Positive discography was not highly predictive in identifying outcomes from spinal fusion. A recent study found only a 27% success from spinal fusion in patients with low back pain and a positive single-level low-pressure provocative discogram, versus a 72% success in patients having a well-accepted single-level lumbar pathology of unstable spondylolisthesis. (Carragee, 2006) The prevalence of positive discogram may be increased in subjects with chronic low back pain who have had prior surgery at the level tested for lumbar disc herniation. (Heggeness, 1997) Invasive diagnostics such as provocative discography have not been proven to be accurate for diagnosing various spinal conditions, and their ability to effectively guide therapeutic choices and improve ultimate patient outcomes is uncertain. (Chou, 2008) Although discography, especially combined with CT scanning, may be more accurate than other radiologic studies in detecting degenerative disc disease, its ability to improve surgical outcomes has yet to be proven. It is routinely used before IDET, yet only occasionally used before spinal fusion. (Cohen, 2005) Provocative discography is not recommended because its diagnostic accuracy remains uncertain, false-positives can occur in persons without low back pain, and its use has not been shown to improve clinical outcomes. (Chou2, 2009) This recent RCT concluded that, compared with discography, injection of a small amount of bupivacaine into the painful disc was a better tool for the diagnosis of discogenic LBP. (Ohtori, 2009) Discography may cause disc degeneration. Even modern discography techniques using small gauge needle and limited pressurization resulted in accelerated disc degeneration (35% in the discography group compared to 14% in the control group), disc herniation, loss of disc height and signal and the development of reactive endplate changes compared to match-controls. These finding are of concern for several reasons. Discography as a diagnostic test is controversial and in view of these findings the utility of this test should be reviewed. Furthermore, discography in current practice will often include injecting discs with a low probability of being symptomatic in an effort to validate other disc injections, a so-called control disc. Although this strategy has never been confirmed to increase test validity or utility, injecting normal discs even with small gauge needles appears to increase the rate of degeneration in these discs over time. The phenomenon of accelerated adjacent segment degeneration adjacent to fusion levels may be, in part, explained by previous disc puncture if discography was used in segments adjacent

	to the fusion. Similarly, intradiscal therapeutic strategies (injecting steroids, sclerosing agents, growth factors, etc.) have been proposed as a method to treat, arrest or prevent symptomatic disc disease. This study suggests that the injection procedure itself is not completely innocuous and a recalculation of these demonstrated risks versus hypothetical benefits should be considered. (Carragee, 2009) More in vitro evidence that discography may cause disc degeneration. (Gruber, 2012) Discography involves the injection of a water-soluble imaging material directly into the nucleus pulposus of the disc. Information is then recorded about the pressure in the disc at the initiation and completion of injection, about the amount of dye accepted, about the configuration and distribution of the dye in the disc, about the quality and intensity of the patient's pain experience and about the pressure at which that pain experience is produced. Both routine x-ray imaging during the injection and post-injection CT examination of the injected discs are usually performed as part of the study. There are two diagnostic objectives: (1) to evaluate radiographically the extent of disc damage on discogram and (2) to characterize the pain response (if any) on disc injection to see if it compares with the typical pain symptoms the patient has been experiencing. Criteria exist to grade the degree of disc degeneration from none (normal disc) to severe. A symptomatic degenerative disc is considered one that disperses injected contrast in an abnormal, degenerative pattern, extending to the outer margins of the annulus and at the same time reproduces the patient's lower back complaints (concordance) at a low injection pressure. Discography is not a sensitive test for radiculopathy and has no role in its confirmation. It is, rather, a confirmatory test in the workup of axial back pain and its validity is intimately tied to its indications and performance. As stated, it is the end of a diagnostic workup in a patient who has failed all reasonable conservative care and remains highly symptomatic. Its validity is enhanced (and only achieves potential meaningfulness) in the context of an MRI showing both dark discs and bright, normal discs -- both of which need testing as an internal validity measure. And the discogram needs to be performed according to contemporary diagnostic criteria -- namely, a positive response should be low pressure, concordant at equal to or greater than a VAS of 7/10 and demonstrate degenerative changes (dark disc) on MRI and the discogram with negative findings of at least one normal disc on MRI and discogram. See also Functional anesthetic discography (FAD). **Discography is Not Recommended in ODG.** **Patient selection criteria for Discography if provider & payor agree to perform anyway:** o Back pain of at least 3 months duration o Failure of recommended conservative treatment including active physical therapy o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection) o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided) o Intended as screening tool to assist surgical decision making, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) (Carragee, 2006) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure. However. all of the qualifying conditions must be met prior to proceeding to discography as discography should be viewed as a non-diagnostic but confirmatory study for selecting operative levels for the proposed surgical procedure. Discography should not be ordered for a patient who does not meet surgical criteria. o Briefed on potential risks and benefits from discography and surgery o Single level testing (with control) (Colorado, 2001)

	o Due to high rates of positive discogram after surgery for lumbar disc herniation, this should be potential reason for non-certification

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)**