

# AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** March 18, 2014

**IRO CASE #:**

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

Comprehensive psych diagnostic interview Psychological testing (90791-  
Psychiatric diagnostic evaluation, 96101-Psychological testing, per hour of  
psychologist's or physician's time, both face-to-face time administering tests to the  
patient and time interpreting these test results and preparing the report, 96102-  
Psychological testing, with qualified health care professional interpretation and  
report, administered by technician, per hour of technician time, face-to-face)

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

This physician is Board Certified Orthopaedic Surgeon with over 15 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:**

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who has failure of conservative treatment for back pain  
and leg pain. She sustained an on-the-job injury on xx/xx/xx. She has failed  
conservative treatment to include exercise program, medications, chiropractic  
care, and epidural steroid injections. She has had EMG/NCV performed and has  
seen psychological clearance for surgery. Claimant is no longer willing to live with  
her current symptomatology and cannot currently work in this condition.

01-21-14: New Patient Surgical Consultation. Chief complaint: back pain and bilateral leg pain, worse on the right than on the left. Radiographs: x-rays of pelvis reveal hips without DJD, sacroiliac joints without sclerosis or focal findings. X-rays of her lumbar spine include flexion-extension views reveal functional spinal unit collapse at L3-4, L4-5, and L5-S1 measuring respectively, functional spinal unit at L3-4 of 2 mm, L4-5 of 5 mm, and L5-S1 of 5 mm associated with facet subluxation and foraminal stenosis. Normal functional spine unit standing is 14 mm. This gives her a translational functional spinal unit collapse of 10 mm and L3-4, 7 mm at L4-5 and L5-S1. L3-4, L4-5, and L5-S1 meet the clinical instability criteria for lumbar spine fusion selection patients of ODG #2, #3, and #5, Clinical Instability Checklist associated with cauda equina damage. Claimant also has a scoliosis on AP view nonfixed, appears balanced. PE: Physical examination of her back and lower extremities reveals mild paravertebral muscle spasm, positive spring test at interiliac crest line, positive extensor lag, and positive sciatic notch tenderness bilaterally although worse on the right, and negative Fortin finger test. Positive flip test bilaterally, positive Lasegue's bilaterally at 50 degrees, and positive Bragard's on the right. Hypoactive knee jerk bilaterally, absent posterior tibial tendon jerks bilaterally, absent ankle jerk on the right, paresthesias in the L4, L5, and S1 nerve root distribution on the right, S1 nerve root distribution on the left with weakness of gastroc-soleus bilaterally, and extensor hallucis longus and tibialis anterior on the right with some quadriceps weakness on the right. Assessment: Internal disc disruption syndrome with stenosis, clinical instability, and discogenic pain with failure of conservative treatment. Plan: Claimant has two options: accept her current disability and continue with conservative treatment or proceed with surgical intervention; she opted surgery. Procedure to correct her clinical instability, stenosis and discogenic pain would be decompression and instrumented arthrodesis with implantable bone growth stimulator as this is more than two levels. We will proceed through the scheduling requirements of her insurance carrier through workmen's compensation program.

01-22-14: Pre-authorization Request Letter dictated by LCSW. Diagnosis: 722.10. Services requested: Comprehensive diagnostic interview 90791 x 1 units, Psychological testing 96101 or 96102 x 3 units. The treating doctor referred claimant for a pre-surgical evaluation to determine if the patient is psychologically stable to undergo any surgical intervention, which is found necessary for the success of the claimant's recovery. In order to be helpful, a comprehensive diagnostic interview with psychological testing to aid in the diagnostic assessment, treatment, level of care planning and discharge.

01-22-14: MRI Scan Review: Lumbar/ Spine. Review of MRI lumbar spine 4/18/12 revealed L3-4 and L4-5 non-contained disc herniation rated at stage III with annular herniation, nuclear extrusion, and spinal stenosis. L5-S1 contained disc herniation rated at stage II with annular herniation, nuclear protrusion, and spinal stenosis. We would recommend provocation discography to delineate clinical symptomatology if indicated.

01-28-14: Referral Form. Referral for EMG/NCV: LE report, Psychological Evaluation: pre-surgical. Diagnosis: 722.10.

02-10-14: UR. Reason for denial: Recommend adverse determination. Although documents that this is a pre-op psych evaluation, there is no credible reason to suspect that the claimant is a surgical candidate. There is no ODG support for lumbar fusion for this patient as recommends. Thus, pre-op psych evaluation is not necessary or relevant. The claimant was previously non-authorized for LESIs due to lack of neurocompressive pathology. The claimant was previously approved for a work hardening program on 3/1/13 and there has been no UR activity since that date. She has already had a psych evaluation on 3/5/12. This claimant only has a 2 level spondylosis without nerve root compression. ODG does not support fusion for this claimant.

02-25-14: UR. Reason for denial: There is no documentation of a previous adverse determination due to lack of documentation of support for lumbar fusion in this patient. Therefore, a pre-op psychiatric evaluation is not necessary. ODG recommends psychological screening 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 and Waddell signs. However, there are no additional medical records for review. There remains no clear indication that this claimant is a surgical candidate. There is no evidence of neurocompressive pathology or instability that would necessitate surgical intervention. The record also indicates that the claimant underwent a previous psychological evaluation. This record is not included for review. Recommend non-certification.

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

The previous adverse determinations are upheld and agreed upon. The claimant does not require psychological testing, as she is not indicated for spinal fusion at the present time. Prior to consideration for a lumbar fusion, the Official Disability Guidelines (ODG) requires evidence of spinal instability or progressive neurological dysfunction. analysis of the flexion and extension views is confusing. It is unclear from his review of the images whether true spinal instability exists in this patient. There is no evidence of progressive neurological dysfunction in the medical record. The current degree of nerve compression is not well-defined. The most recent MRI of the lumbar spine is dated 4/18/2012. An up-to-date MRI would be required before considering a decompressive procedure performed at the time of fusion. After reviewing the medical records and documentation provided, the claimant is not a surgical candidate and therefore does not require psychological screening. The request for Comprehensive psych diagnostic interview Psychological testing (90791-Psychiatric diagnostic evaluation, 96101-Psychological testing, per hour of psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report, 96102-Psychological testing, with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face) is denied.

Per ODG:

Psychological screening	<p>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. However, the screening should be performed by a neutral independent psychologist or psychiatrist unaffiliated with treating physician/ spine surgeon to avoid bias. (<a href="#">Scalzitti, 1997</a>) (<a href="#">Fritz, 2000</a>) (<a href="#">Gaines, 1999</a>) (<a href="#">Gatchel, 1995</a>) (<a href="#">McIntosh, 2000</a>) (<a href="#">Polatin, 1997</a>) (<a href="#">Riley, 1995</a>) (<a href="#">Block, 2001</a>) (<a href="#">Airaksinen, 2006</a>) A recent study concluded that psychological distress is a more reliable predictor of back pain than most diagnostic tests. (<a href="#">Carragee, 2004</a>) 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. (<a href="#">Shekelle, 2008</a>) Two factors from the adapted stress process model, <i>cognitive appraisal</i> and <i>emotional distress</i>, were identified as significant predictive factors of number of days of absence at 12 months and functional disability at 6 and 12 months. The adapted stress process model suggested that psychological variables act differently according to the variable predicted and to the period of time considered. (<a href="#">Truchon, 2010</a>) The most helpful components for predicting persistent disabling low back pain were maladaptive pain coping behaviors, nonorganic signs, functional impairment, general health status, and presence of psychiatric comorbidities. (<a href="#">Chou, 2010</a>) In workers' comp it is recommended to screen for presurgical biopsychosocial variables because they are important predictors of discectomy outcomes. (<a href="#">DeBerard, 2011</a>) For more information, see the <a href="#">Pain Chapter</a>, including Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients, and the <a href="#">Stress/Mental Chapter</a>.</p>
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**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)**