

Independent Resolutions Inc.

An Independent Review Organization

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DATE OF REVIEW:

09/10/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1 X 6 wks

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

Licensed Psychologist

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

03-21-07 Consultation note by MD
03-30-07 Initial Behavioral Medicine Consultation note by LPC
04-05-07 Consultation note by Dr. DO Behavioral Medicine
05-04-07 Consultation note by Dr. DO Behavioral Medicine
05-17-07 Behavioral Medicine testing results by LPC
07-30-07 First denial letter by MD
07-21-07 Second denial letter by PhD
08-09-07 Reconsideration request letter by LPC
08-16-07 Second denial letter by Dr. PhD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured at work while performing his job duties as an . Patient reports having worked for the present employer for the past 6

month, and on the date of the injury, was waiting for paper to be loaded onto pallets when the forklift driver ran into him, causing the pallets to fall on him. Patient reports feeling immediate pain to the right knee, and went to Med Clinic with his injury. He was given an MRI and a leg brace. He subsequently transferred his care to Healthcare. Dr.'s note of 3-21-07 reports that the MRI was positive for MCL avulsion injury, and that patient was referred for a surgical consult. Dr. diagnosed him with right knee internal derangement status post avulsion injury, pending surgery; and significant mood disturbance directly related to his work injury. Patient's pain level was an 8.5/10, and self-reported anxiety and depression were at a 10/10. Patient's pain medication was increased from Ultram 50 tid to Vicodin for the severe pain, Lexapro was increased to 2 qhs, and Hydrochlorothiazide 25 mg qd was added.

On 3-30-07, patient was seen for a behavioral med consult. Her report detailed patient subjective quantifying of severe pain (10/10), depression (7/10), and self-reported anxiety, as well as sleep difficulties, self-esteem issues, and reduced ADL's. BDI and BAI scores were incongruent with impression given by patient during the interview, with BDI being 19 (mild) and BAI being a 4 (WNL). Patient was diagnosed with adjustment disorder with mixed anxiety and depressed mood, and testing was requested to better determine treatment planning, and was apparently approved.

On 04-05-07, patient was seen by Dr. for an office visit. At that time, Wellbutrin XL 150 was added to the regimen of Vicodin, Ultram, Lexapro, and Robaxin. On 05-04-07, Dr. added Hydrochlorothiazide. Patient was still reporting severe pain, depression and anxiety levels.

Psychological testing was completed on 5-17-07, with noted concerns raised on the BHI-2 regarding patient's lack of pain variability and expectation that he needs to be pain free. The MBMD showed patient's injury-related decreased self-perception and patient coping by becoming more socially withdrawn. Diagnosis was 307.89 pain disorder associated with both psychological factors and a general medical condition. Request was for 6 IT sessions to address these stated concerns.

On 6-6-07, patient saw Dr. for an office visit. His pain was still an 8.5/10, but Lexapro was helping the depression and anxiety, both rated at 4/10. Wellbutrin was discontinued and the rest of the meds stayed the same. Patient at this time needed a crutch to ambulate. He continued to need surgery.

Request for IT's was denied on 7-30-07 by Dr. as she believed since surgery was scheduled for a month away, there would be no time for pre-surgical counseling. She states that "The request for individual psychotherapy, with documentation detailing a right knee arthroscopic surgery as scheduled and pending 8-27-07, is not consistent with ODG recommendations".

Request for reconsideration was sent on 8-9-07, with clarification that IT's were not specifically requested pre-surgically, but overall, to deal with patient's injury-related pain and mental health issues.

Second denial was issued 8-16-07, after Dr. 's peer to peer with a Dr. Dr. stated that the IT's would be conducted both before and after surgery. Dr. denied the request, stating that "issues noted upon approval for psych testing were not adequately clarified in relation to the preparation for surgery".

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

There appears to be confusion in this case regarding the initial intent when the referral was made for a behavioral medicine consult, which suggested psychological testing to "assist in identifying other issues, including personality features that may be impacting his [patient's] recovery". Since the patient was also being referred at the same time for surgery, this is possibly where the confusion originated, although patient's appropriateness for surgery was never addressed in either the behavioral medicine consult or the resulting psych testing or the request for the 6 IT sessions.

Of course, IT prior to surgery could have been helpful to aid patient in preparing for surgery and the outcome of surgery, which may be below his stated expectations of "total pain relief". At least 4 of these sessions could have been completed prior to surgery. Per ODG: 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](#))

However, since poor coping skills, depressed mood, and dependant personality traits have not changed since surgery, and since testing results warned about slow recovery process for this patient, IT sessions as this time could still fulfill the goals for treatment as originally stated. Per ODG: 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](#))

Psychological evaluations: Recommended. 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](#)) 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](#))

Patient's diagnoses of pain disorder and adjustment disorder are not disputed. ODG recommends cognitive therapy for depression, stating that "the gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy." Patient has shown some positive response to the psychotropic medication prescribed for him, and this is a good prognostic indicator of success with individual therapy.

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)**