

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 04/17/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

6 sessions of Individual psychotherapy

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:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Upon independent review the reviewer finds that the requested 6 sessions of individual psychotherapy are medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 1/25/08, 2/27/08
ODG Guidelines and Treatment Guidelines
Behavioral Assessment 1/7/08
URA Notes 1/22/08, 1/23/08, 2/21/08, 2/26/08
MD Follow-Up Office Visit Notes 1/14/08, 2/11/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured at work while performing her usual job duties, following repetitive lifting of weights greater than 20 pounds. Patient reports finishing her shift early due to lumbar pain, and going to the ER that night. She has since received conservative, secondary, and tertiary treatments/diagnostics to include 6 back surgeries with multiple fusions and hardware removal, and implantation of a morphine pump, which was removed 6 months later due to adverse side effects. She has additionally received injections, physical therapy, work hardening, individual psychotherapy, aquatic therapy, and a chronic pain program. Current prescribed medications include: Oxycontin, Xanax, Cymbalta, Morphine, Provigil, Zanaflex, Lyrica, and Ambien.

On 1/7/08, patient was referred for, and received, a behavioral pre-surgical assessment relative to a trial for a spinal cord stimulator. On a Brief Pain Inventory, patient reported pain in the lower lumbar and bilateral lower extremities as 8/10, with medications. Her Beck Depression Inventory indicated severe levels of depression, and her PAIRS was significantly elevated. Her Beck Anxiety Inventory was normal. Requestor is stating that patient is not psychologically appropriate for surgery at this time, and is requesting 1x6 individual therapy sessions in order to “treat her depression” and “learn more effective coping skills...”

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

Although patient has failed numerous interventions, she continues to seek help for her documented chronic pain problem. The previous denials incorrectly applied the ODG. Pre-screen evaluation for SCS surgery was apparently approved based on the following ODG recommendations, which include follow through with individual counseling for patients “especially” such as this one. (See below; ODG, 6th edition, 2008). As such, the request 6 IT sessions are considered reasonable and necessary.

Psychological evaluations; IDDS and SCS: 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](#)):

(1) A clinical interview including the following: (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.

(2) An interview with a significant other (if approved by the patient) to confirm findings, alert for other significant information, and allow for assessment of social support.

(3) Psychological testing. 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, 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). Post-evaluation, three general categories of patients have been identified:

- Group 1: Patients with no contraindications for implantation

- Group 2: 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.

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.

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.

- Group 3: 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.

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)**