

Applied Assessments LLC

An Independent Review Organization
1124 N. Fielder Road, #179, Arlington, TX 76012
(512) 772-1863 (phone)
(512) 857-1245 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 08/16/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1X6

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters-6/18/08; 7/9/08
Records from -6/10/08-7/9/08
Records from -4/17/08-6/23/08
MRI-5/27/08
FCE-7/3/08
Advanced Diagnostics 6/10/08
Dr -5/22/08-6/10/08
Dr. -4/23/08-4/29/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured at work on xx/xx/xx. At the time, he was performing his usual job duties. On the above mentioned date, while attempting to move 5 baskets of parts that were on a rolling cart, as he was trying to turn,

patient reports that he felt sharp and immediate pain in his low back. Four days later, patient reported the incident to his supervisor, and received treatment from the company doctor, who evaluated him and prescribed pain medications. Patient transferred his care to Dr. on xx/xx/xx. Patient has since returned to work at a light duty status.

Claimant has received the following diagnostics and treatments to date: x-rays, MRI, EMG/NCV, physical therapy, and medications management. Office note of 5-21-08 records patient report of pain in the lumbar spinal region radiating down his right leg. Patient also had complaints of numbness, tingling, stiffness and soreness in the lumbar spinal region and right leg. At the time, he rated his pain as 9/10, stating the pain couldn't be ignored for long.

MRI done on 05/27/2008 showed L2-L3 3-4 mm annular bulge and L3-L4 and L4-L5 5-6mm posterior central disc protrusions moderately indenting the thecal sac. EMG/NCV done on June 13th showed nerve compression at L4-L5. Patient was applied physical therapy and, per patient report, is prescribed Skelaxin and Hydrocodone for pain.

On 06-10-08, patient was interviewed and evaluated by LPC, in order to make psychological treatment recommendations. Patient was administered the patient symptom rating scale, BDI and BAI, along with an initial interview and mental status exam. At the time of the interview, patient rated his average pain level at 5/10, with spikes to 7/10, and stated he has less involvement in family and social activities. On the PSRS, patient had no clinically significant numbers, except he rated "vocational problems" at 9/10 and "insurance claim issues" at 10/10. BDI was a 12 and BAI was 9, both in the mild or minimal ranges. Patient was diagnosed with 309.28 adjustment disorder with anxiety and depressed mood, secondary to the work injury.

Follow-up physician's office note of 7/25/08 shows patient reporting decreased pain and his overall condition as being "favorable..." "He appears to handle light-duty work with little aggravation" was noted, and patient was allowed to stay at work light duty, pending an ortho evaluation.

The current request is for individual cognitive-behavioral therapy 1x6. Goals are to decrease the patient's reported irritability from 3/10 to 1/10, help patient challenge and replace his negative cognitions, and improve sleep.

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

The goals for treatment discussed above are difficult to decipher, given that the only standardized tests employed showed no significant subjective levels of distress. Specific goals of utilizing CBT to "reduce the patient's low mood as affective distress reflects feeling overwhelmed by stressors that tax limited coping and problem-solving skills" make no sense, as it is then recommended that part of therapy would be used to assess patient's current coping repertoire.

Likewise, the goal of replacing negative cognitions is presumptive, since patient's subjective measures do not evidence negative cognitions.

There is currently no evidence of delayed recovery, as physiologic pain generators have yet to be address until the Ortho consult. Sleep maintenance problems also appear primary in nature, and ODG recommends pharmacological treatment for this.

In addition, the ODG TWC stress chapter states that initial evaluations should “focus on identifying possible red flags or warning signs for potentially serious psychopathology that would require immediate specialty referral. Red flags may include impairment of mental functions, overwhelming symptoms, signs of substance abuse, or debilitating depression. In the absence of red flags, the occupational or primary care physician can handle most common stress-related conditions safely”. The determination that medical necessity could not be established at this time is upheld. (*See the following from ODG Work Loss Data, 2007*):

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](#))

Bruns D. Colorado Division of Workers' Compensation, Comprehensive Psychological Testing: Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients. 2001

This comprehensive review shows test name; test characteristics; strengths and weaknesses; plus length, scoring options & test taking time. The following 26 tests are described and evaluated:

- 1) 1) BHI™ 2 (Battery for Health Improvement – 2nd edition)
- 2) 2) MBHI™ (Millon Behavioral Health Inventory)
- 3) 3) MBMD™ (Millon Behavioral Medical Diagnostic)
- 4) 4) PAB (Pain Assessment Battery)
- 5) 5) MCMI-111™ (Millon Clinical Multiaxial Inventory, 3rd edition)
- 6) 6) MMPI-2™ (Minnesota Inventory- 2nd edition™)
- 7) 7) PAI™ (Personality Assessment Inventory)
- 8) 8) BBHI™ 2 (Brief Battery for Health Improvement – 2nd edition)
- 9) 9) MPI (Multidimensional Pain Inventory)
- 10) 10) P-3™ (Pain Patient Profile)
- 11) 11) Pain Presentation Inventory
- 12) 12) PRIME-MD (Primary Care Evaluation for Mental Disorders)
- 13) 13) PHQ (Patient Health Questionnaire)
- 14) 14) SF 36™
- 15) 15) (SIP) Sickness Impact Profile
- 16) 16) BSI® (Brief Symptom Inventory)
- 17) 17) BSI® 18 (Brief Symptom Inventory-18)
- 18) 18) SCL-90-R® (Symptom Checklist –90 Revised)
- 19) 19) BDI®-II (Beck Depression Inventory-2nd edition)

- 20) 20) CES-D (Center for Epidemiological Studies Depression Scale)
- 21) 21) PDS™ (Post Traumatic Stress Diagnostic Scale)
- 22) 22) Zung Depression Inventory
- 23) 23) MPQ (McGill Pain Questionnaire)
- 24) 24) MPQ-SF (McGill Pain Questionnaire – Short Form)
- 25) 25) Oswestry Disability Questionnaire
- 26) 26) Visual Analogue Pain Scale (VAS)

All tests were judged to have acceptable evidence of validity and reliability except as noted. Tests published by major publishers are generally better standardized, and have manuals describing their psychometric characteristics and use. Published tests are also generally more difficult to fake, as access to test materials is restricted to qualified professionals. Third party review (by journal peer review or Buros Institute) supports the credibility of the test. Test norms provide a benchmark to which an individual's score can be compared. Tests with patient norms detect patients who are having unusual psychological reactions, but may overlook psychological conditions common to patients. Community norms are often more sensitive to detecting psychological conditions common to patients, but are also more prone to false positives. Double normed tests (with both patient and community norms) combine the advantages of both methods. Preference should be given to psychological tests designed and normed for the population you need to assess. Psychological tests designed for medical patients often assess syndromes unique to medical patients, and seek to avoid common pitfalls in the psychological assessment of medical patients. Psychological tests designed for psychiatric patients are generally more difficult to interpret when administered to medical patients, as they tend to assume that all physical symptoms present are psychogenic in nature (i.e. numbness and tingling may be assumed to be a sign of somatization). This increases the risk of false positive psychological findings. Tests sometimes undergo revision and features may change. When a test is updated, the use of the newer version of the test is strongly encouraged. Document developed by Daniel Bruns, PsyD and accepted after review and revisions by the Chronic Pain Task Force, June 2001. Dr. Bruns is the coauthor of the BHI 2 and BBHI 2 tests.

Rating: 7a

Psychological treatment: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, *conceptualizing a patient's pain beliefs and coping styles*, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. 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](#))

Behavioral Treatment: Recommended as option for patients with chronic low back pain and delayed recovery. Also recommended as a component of a Chronic pain program (see the [Pain Chapter](#)). Behavioral treatment, specifically cognitive behavioral therapy (CBT), may be an effective treatment for patients with chronic low back pain, but it is still unknown what type of patients benefit most from what type of behavioral treatment. Some studies provide evidence that intensive multidisciplinary bio-psycho-social rehabilitation with a functional restoration approach improves pain and function. ([Newton-John, 1995](#))

([Hasenbring, 1999](#)) ([van Tulder-Cochrane, 2001](#)) ([Ostelo-Cochrane, 2005](#)) ([Airaksinen, 2006](#)) ([Linton, 2006](#)) ([Kaapa, 2006](#)) ([Jellema, 2006](#)) Recent clinical trials concluded that patients with chronic low back pain who followed cognitive intervention and exercise programs improved significantly in muscle strength compared with patients who underwent lumbar fusion or placebo. ([Keller, 2004](#)) ([Storheim, 2003](#)) ([Schonstein, 2003](#)) Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate on this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). ([Lang, 2003](#)) A recent RCT concluded that lumbar fusion failed to show any benefit over cognitive intervention and exercises, for patients with chronic low back pain after previous surgery for disc herniation. ([Brox, 2006](#)) Another trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. (The cognitive treatment focused on encouraging increased physical activity.) ([Smeets, 2006](#)) For chronic LBP, cognitive intervention may be equivalent to lumbar fusion without the potentially high surgical complication rates. ([Ivar Brox-Spine, 2003](#)) ([Fairbank-BMJ, 2005](#)) See also Multi-disciplinary pain programs in the [Pain Chapter](#).

ODG cognitive behavioral therapy (CBT) guidelines for low back problems:

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See [Fear-avoidance beliefs questionnaire](#) (FABQ).

Initial therapy for these “at risk” patients should be [physical therapy exercise](#) instruction, using a cognitive motivational approach to PT.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks
- With evidence of objective [functional improvement](#), total of up to 6-10 visits over 5-6 weeks (individual sessions)

Insomnia, treatment: Recommend that treatment be based on the etiology, with the medications recommended below. See [Insomnia](#). Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning.

Pharmacologic Treatment: There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin receptor agonists; & (4) Over-the-counter medications. The majority of studies have only evaluated short-term treatment (i.e., ≤ 4 weeks) of insomnia; therefore more studies are necessary to evaluate the efficacy and safety of treatments for long-term treatment of insomnia. In 2007, the FDA requested that manufacturers of all sedative-hypnotic drugs strengthen product labeling regarding risks (i.e., severe allergic reactions and complex sleep-related behaviors, such as sleep driving). It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. ([Morin, 2007](#)) ([Reeder, 2007](#)) (1) **Benzodiazepines:** FDA-approved benzodiazepines for sleep maintenance insomnia include estazolam (ProSom®), flurazepam (Dalmane®), quazepam (Doral®), and temazepam (Restoril®). Triazolam (Halcion®) is FDA-approved for sleep-onset insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Decrease slowly and monitor for withdrawal symptoms. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use. ([Holbrook, 2000](#)) ([Ramakrishnan, 2007](#)) ([Buscemi, 2007](#)) ([Morin, 2007](#)) ([Wafford, 2008](#)) ([Benca, 2005](#)). (2) **Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists):** First-line medications for insomnia. This class of medications includes zolpidem (Ambien® and Ambien® CR), zaleplon (Sonata®), and eszopicolone (Lunesta®). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which means they have potential for abuse and dependency. Although direct comparisons between benzodiazepines and the non-benzodiazepine hypnotics have not been studied, it appears that the non-benzodiazepines have similar

efficacy to the benzodiazepines with fewer side effects and short duration of action. ([Ramakrishnan, 2007](#)) ([Halas, 2006](#)) ([Buscemi, 2007](#)) ([Morin, 2007](#)) ([Erman, 2005](#)) **Zolpidem** [*Ambien*® (*generic available*), *Ambien CR*™] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). *Ambien CR* is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found *Ambien CR* to be effective for up to 24 weeks in adults. ([Buscemi, 2005](#)) ([Ramakrishnan, 2007](#)) ([Morin, 2007](#)). The extended-release dual-layer tablet (*Ambien CR*™) has a biphasic release system; an initial release of zolpidem reduces sleep latency and a delayed release facilitates sleep maintenance. *Side effects*: headache, daytime drowsiness, dizziness, blurred vision, confusion, abnormal thinking and bizarre behavior have occurred. Sleep driving and other activities for which the patient has no recollection may occur. The medication should be discontinued if the latter occurs. Abrupt discontinuation may lead to withdrawal. *Dosing*: *Ambien* 10 mg at bedtime (5 mg in the elderly and patients with hepatic dysfunction); *Ambien CR* 12.5 mg at bedtime (6.25 mg in the elderly and patients with hepatic dysfunction) ([Morin, 2007](#)). **Zaleplon** (*Sonata*®) reduces sleep latency. *Side effects*: headache, drowsiness, dizziness, fatigue, confusion, abnormal thinking. Sleep-related activities have also been noted such as driving, cooking, eating and making phone calls. Abrupt discontinuation may lead to withdrawal. *Dosing*: 10 mg at bedtime (5 mg in the elderly and patients with hepatic dysfunction). ([Morin, 2007](#)) Because of its short half-life (one hour), may be readministered upon nocturnal awakening provided it is administered at least 4 hours before wake time. ([Ramakrishnan, 2007](#)) This medication has a rapid onset of action. Short-term use (7-10 days) is indicated with a controlled trial showing effectiveness for up to 5 weeks. **Eszopiclone** (*Lunesta*™) has demonstrated reduced sleep latency and sleep maintenance. ([Morin, 2007](#)) The only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. A randomized, double blind, controlled clinical trial with 830 primary insomnia patients reported significant improvement in the treatment group when compared to the control group for sleep latency, wake after sleep onset, and total sleep time over a 6-month period. ([Walsh, 2007](#)) *Side effects*: dry mouth, unpleasant taste, drowsiness, dizziness. Sleep-related activities such as driving, eating, cooking and phone calling have occurred. Withdrawal may occur with abrupt discontinuation. *Dosing*: 1-2 mg for difficulty falling asleep; 2-3 mg for sleep maintenance. The drug has a rapid onset of action. ([Ramakrishnan, 2007](#)) **Sedating antidepressants** (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia ([Buscemi, 2007](#)) ([Morin, 2007](#)), but they may be an option in patients with coexisting depression. ([Morin, 2007](#)) Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Improvements in sleep onset may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation. (3) **Melatonin-receptor agonist: Ramelteon** (*Rozerem*™) is a selective melatonin agonist (MT₁ and MT₂) indicated for difficulty with sleep onset; is nonscheduled (has been shown to have no abuse potential). One systematic review concluded that there is evidence to support the short-term and long-term use of ramelteon to decrease sleep latency; however, total sleep time has not been improved. ([Reynoldson, 2008](#)). ([Zammit, 2007](#)) Ramelteon is not a controlled substance. *Side effects*: CNS depression, somnolence, dizziness, fatigue, abnormal thinking and bizarre behavior have occurred. Use with caution in patients with depression, hepatic impairment, and respiratory conditions such as COPD or sleep apnea. *Dosing*: 8mg within 30 minutes of bedtime; recommended for short-term (7 – 10 days) use only. (4) **Over-the-counter medications**: Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness.

Non-pharmacologic treatment: Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. Treatments that are thought to probably be efficacious include sleep restriction, biofeedback, and multifaceted cognitive behavioral therapy. **Suggestions for improved sleep hygiene**: (a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping. ([Benca, 2005](#))

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)