

True Resolutions Inc.

An Independent Review Organization

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Corrected Amended Decision July 7, 2008

July 7, 2008

DATE OF REVIEW: 07/06/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Health and behavioral assessment for 1 visit and/or health and behavioral intervention with biofeedback monitoring for 2 X week X 5 weeks.

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 5/7/08 and 5/29/09

Medical Records: Reconsideration Letter 5/15/08; Chronic Pain Eval 4/7/08 and 4/22/08

Medical Records from Medical Clinic: EMG 8/23/05; 5/4/07, 5/7/07, 6/6/07, 1/18/08, 1/25/08, 2/18/08, 3/19/08

MRI's 4/3/04 and 7/15/05

CT Lumbar Spine 12/16/04

Medical Records from Dr. 2/6/07

Records from: Dr. 5/5/04 and 3/19/04; Dr. 6/23/04; Dr. 2/18/05; Dr. 6/14/05; Dr. 3/22/06 and 8/6/04; Dr. 4/3/04; Dr. 6/30/04; Dr. 2/1/05

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured at work on xx/xx/xx. At the time, she was performing her usual job duties. She was in the process of counting inventory, and was on a ladder, when she slipped and fell, injuring her neck, low back, left elbow, and left shoulder. Since then, she has not returned to work.

Claimant has received the following diagnostics and treatments to date: MRI's, CT scan (cervical), EMG (positive), physical therapy, surgery, and medications management. Specifically, claimant had acromioplasty and distal clavicle resection with repair of intrasubstance rotator cuff in May 2005. She had an EMG in May 2005 that revealed left ulnar nerve entrapment, cubital tunnel syndrome. In February, 2006, she had a second shoulder surgery where she had shoulder scope for release of adhesions, open bursectomy, and acromioplasty. Cervical MRI from 2005 revealed 1 and 2 mm broad based disc bulges/protrusions at C3-C7. Claimant's current treating doctor states that the claimant "continues to experience severe disabling pain and rigidity in her neck and lower back pain as a result of this accident. She has very limited ROM in her cervical and lumbar spine and experiences weakness and paresthesias in her arms and legs. She has not been able to return to work since her injury and in my medical opinion, I do not believe that she is capable of even performing sedentary job duties at this time." He referred her for a psychological evaluation to assess appropriateness for a chronic pain management program. Current diagnoses include: cervical pain, lumbar disc disruption, left ulnar nerve entrapment, S/P arthroplasty of the left shoulder x 2, and pain disorder associated with medical condition and psychological factors. Medications include Celexa, Trazadone, Xanax, Ambien, Lortab, and Soma.

On 04-22-08, patient was interviewed and evaluated by, PsyD, in order to make psychological treatment recommendations. Patient was administered the BHI-II, MMPI, and FABQ, along with an initial interview and mental status exam. Results indicated that the patient had developed a chronic pain syndrome "characterized by somatic preoccupation, pain sensitization, depression, anxiety, anger, and alienation. The patient also appears somewhat emotionally immature with a tendency to overemphasize or overreact to problems. She also has very strong fear-avoidance beliefs regarding both work and everyday physical activities". Patient is not able currently to participate in a CPMP due to scheduling problems, and current request is for health and behavioral intervention with biofeedback monitoring for 2 X week X 5 weeks and behavioral assessment. Goal is to decrease the patient's level of muscle tension and pain and therefore decrease her fear-avoidance beliefs and need for narcotic medication utilizing behavioral therapy accompanied by biofeedback monitoring and instruction in relaxation techniques.

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

A diagnostic interview with testing and recommendations was requested by the patient's treating doctor, and has been conducted. The results indicate that patient could benefit from cognitive-behavioral and relaxation interventions aimed at improving coping skills in order to reduce pain, disability mindset, and associated fears. A stepped-care approach to treatment has been followed, as per ODG, and the requested evaluation and sessions appear reasonable and necessary to treat the issues arising from the patient's injury-related pain and off-work status with a goal of increased overall physical and emotional functioning.

ODG Work Loss Data, 2008, Texas

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

Comorbid psychiatric disorders: Recommend screening for psychiatric disorders. Comorbid psychiatric disorders commonly occur in chronic pain patients. In a study of chronic disabling occupational spinal disorders in a large tertiary referral center, the overall prevalence of psychiatric disorders was 65% (not including pain disorder) compared to 15% in the general population. These included major depressive disorder (56%), substance abuse disorder (14%), anxiety disorders (11%), and axis II personality disorders (70%). ([Dersh, 2006](#)) When examined more specifically in an earlier study, results showed that 83% of major depression cases and 90% of opioid abuse cases developed after the musculoskeletal injury. On the other hand, 74% of substance abuse disorders and most anxiety disorders developed before the injury. This topic was also studied using the National Comorbidity Survey Replication (NCS-R), a national face-to-face household survey. ([Dersh, 2002](#)) See also [Psychological evaluations](#).

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](#))

CBT: Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). ([Paykel, 2006](#)) ([Bockting, 2006](#)) ([DeRubeis, 1999](#)) ([Goldapple, 2004](#)) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. ([Gloaguen, 1998](#)) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. ([Thase, 1997](#)) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. ([Corey-Lisle, 2004](#)) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. ([Pampallona, 2004](#)) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. ([Royal Australian, 2003](#)) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. ([Warren, 2005](#))

ODG Psychotherapy Guidelines:

Initial trial of 6 visits over 6 weeks

With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Education (to reduce stress related to illness): Recommended. Patient education consisting of concrete, objective information on symptom management, including disease and treatment information, has been found to help reduce patient stress, especially when combined with emotional support and counseling. ([Rawl, 2002](#))

Psychological Screening: Recommended as an option prior to surgery, or in cases with expectations of delayed recovery.

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)