

SENT VIA EMAIL OR FAX ON
Nov/12/2008

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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/11/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual Psychotherapy 1 X 6.

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

Psychology

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

Denial Letters 9/29/08 and 10/13/08

Records 9/2/08 thru 10/13/08

Records from Dr. 7/23/08 thru 9/11/08

MRI's 7/9/08

ENC 9/13/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured at work on xx/xx/xx. At the time of the injury, he was performing his usual job duties. Claimant reports that he tripped and fell over material that was in the work area, injuring his right shoulder, right hand, and low back. He initially saw a company doctor, who put him on modified duty. He has since transferred his care to Dr. and remains on light duty work with multiple restrictions.

Claimant has received the following diagnostics and treatments to date: x-rays, MRI, EMG, physical therapy (in progress), and medications management. MRI of the right shoulder done

on 7/9/08 revealed right shoulder AC joint disease with subacromial-subdeltoid bursitis and minimal supraspinatus tendonopathy. He is currently diagnosed with cervical, right shoulder, and lumbar strain/sprain; right shoulder tendonopathy and radiculopathy, and possible cervical disk. He has decrease ROM to the cervical and lumbar spine. He is prescribed Lyrica and Darvocet N-100 for pain.

Treating physician referred the patient for a psychological evaluation to assess appropriateness for conservative individual therapy sessions. On 09-02-08, 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. Results indicated that the patient had developed an injury-related adjustment disorder with anxiety, work-related. Patient currently rates his average pain level as a 3/10VAS, stating it moderately interferes with his recreational, social, and family activities (5/10 on a ten-point scale). BDI was a 12 and BAI was a 10. Patient reports decreases in his ability to self-groom, do yard work, exercise/play sports, stand, squat, or lift heavy items. He also reports decreased sexual ability, loss of confidence, feeling useless/helpless, feeling a lack of control, feeling unattractive, and feeling disappointed/angry. Sleep is also disturbed, being reduced from 7 to 4 hours per night. Due to his modified work status, he has financial difficulties which have led to him moving in with his brother and not having a car to visit his children.

The current request is for individual cognitive-behavioral therapy 1x6. Goal is to employ cognitive-behavioral techniques in order to: decrease the patient's low mood, increase his limited coping skills to improve competence, improve problem-solving, and reduce patient's stated irritability, frustration, nervousness, muscle tension, and sleep problems.

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

A diagnostic interview with mental status, 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 injury-related pain, irritable/anxious mood, psychosocial issues, 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 reduced-work status, with a goal of increased overall physical and emotional functioning and keeping patient at work. The request is considered medically reasonable and necessary at this time.

ODG Work Loss Data, 2008, Texa

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. 200

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 Inventor
- 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 Profil
- 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 Inventor
- 23) 23) MPQ (McGill Pain Questionnaire)
- 24) 24) MPQ-SF (McGill Pain Questionnaire – Short Form)
- 25) 25) Oswestry Disability Questionnair
- 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)

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)

Psychotherapy for MDD: Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. (American Psychiatric Association, 2006) See also Cognitive therapy for additional information and references, including specific ODG Psychotherapy Guidelines (number and timing of visits)

Patient selection. Standards call for psychotherapy to be given special consideration if the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans which did not involve psychotherapy

Types of psychotherapy. The American Psychiatric Association has published the following considerations regarding the various types of psychotherapy for MDD

- Cognitive behavioral psychotherapy is preferable to other forms of psychotherapy, because of a richer base of outcome studies to support its use, and because its structured and tangible nature provides a means of monitoring compliance and progress

- In contrast, psychodynamic psychotherapy is not recommended because it has specifically been identified as lacking scientific support, and is severely vulnerable to abuse because it can involve a lack of structure. (American Psychiatric Association, 2006)

Cognitive therapy for general stress Recommended. Stress management that includes cognitive therapy has the potential to prevent depression and improve psychological and physiological symptoms. As with all therapies, an initial trial may be warranted, with continuation only while results are positive. (Mino, 2006) (Granath, 2006) (Siversten, 2006)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)