

IRO Express Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 10/06/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual therapy 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

Psychological Pre-screen Evaluation, 06/22/08

Denial Letters 7/17/08 and 8/15/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female who was injured at work on xx/xx/xx while performing her usual job duties as a on an assembly line. Patient reports she was replacing an empty spool with a full spool when her left foot got caught in a netted pouch, causing her to fall into a steel capstan, injuring the back of her head, neck, left UE, low back, and left LE. Since this time, patient has been off-work due to her injuries, except for a five-day period when she attempted to return to work, but was unsuccessful due to pain interference.

Since the injury, patient has since received conservative, secondary, and tertiary treatments/diagnostics to include x-rays, MRI's, EMG, myelogram, discogram,

cat scan, FCE, physical therapy, work hardening, ESI's, chiropractic care, surgeries, and medications management. Current prescribed medications include: Ultram ER and methacarbonol for muscle spasms.

On 6/22/08, patient was referred for, and received, a behavioral pre-surgical assessment relative to a pending cervical spine surgery. On a Pain Patient Drawing, patient reported pain in the lower lumbar, buttocks, and left thigh as 8/10, with medications. She reported her neck pain at 6/10. Her Beck Depression Inventory of 14 indicated mild levels of depression. Her Beck Anxiety Inventory of 20 showed moderate problems with anxiety. Sleep questionnaire indicated moderate to serious sleep disturbances, related to physical pain, anxieties, medication side effects, and her environment. MMPI-2 profile revealed "a rather mixed pattern of symptoms in which somatic reactivity under stress is a primary difficulty...She view her physical health as failing and reports numerous somatic concerns. She feels that life is no longer worthwhile and that she is losing control of her thought processes... Some individuals with this profile develop patterns of "invalidism" in which they become incapacitated and dependent on others." Patient was given diagnoses of Pain Disorder associated with medical conditions and psychological factors, depressive disorder, NOS, and anxiety disorder NOS. Axis II diagnosis was deferred. Patient was psychologically cleared for surgery, and current request is for 1x6 individual therapy sessions in order to decrease depression, improve sleep, and teach relaxation and pain coping skills.

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

Current request cannot be deemed medically appropriate or necessary at this time, since report and testing results are over 3 months old, and it is presumed that surgery has been accomplished during this interval. At this time, the testing and recommendations made from the testing results are not valid and the patient's current status needs to be re-assessed before any other intervention can be accomplished.

Psychological evaluations: 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](#)) A recent study concluded that psychological distress is a more reliable predictor of back pain than most diagnostic tests. ([Carragee, 2004](#)) The new ACP/APS guideline as compared to the old AHCPR guideline is a bit stronger on emphasizing the need for psychosocial assessment to help predict potentially delayed recovery. ([Shekelle, 2008](#)) For more information, see the [Pain Chapter](#) and the [Stress/Mental Chapter](#).

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.

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) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 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) See "[Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients](#)" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory, (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale - VAS. (Bruns, 2001) Chronic pain may harm the brain, based on using functional magnetic resonance imaging (fMRI), whereby investigators found individuals with chronic back pain (CBP) had alterations in the functional connectivity of their cortical regions - areas of the brain that are unrelated to pain - compared with healthy controls. Conditions such as depression, anxiety, sleep disturbances, and decision-making difficulties, which affect the quality of life of chronic pain patients as much as the pain itself, may be directly related to altered brain function as a result of chronic pain. (Baliki, 2008) See also [Comorbid psychiatric disorders](#). See also the [Stress/Mental 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)