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Notice of Independent Review Decision

DATE OF REVIEW: 4/15/09

IRO CASE #:

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

This case was reviewed by a Psychiatry, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Psychological interview and Psychological testing 3 hours

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records submitted for review, the patient is a employee who sustained an industrial injury to the low back on xx/xx/xxxx. He is status post back surgery on July 10, 2003 and is followed for continuing back pain aggravated by carrying heavy equipment. He has been helped some with chiropractic but not at all with physical therapy.

The medical report of August 7, 2007 indicates the patient is alert and oriented with appropriate affect. The patient has a pre-operative diagnosis of left L4 and L5 lumbar radicular pain. The diagnosis is lumbar postlaminectomy syndrome. A

transforaminal neuroplasty intervention is performed on this visit. At follow-up on August 20, 2007 the patient reported no overall change with the neuroplasty. He reports persisting paresthesia in the left foot.

Lumbar MRI was performed on August 24, 2007 and shows no evidence for residual or recurrent disc herniation. There is mild disc narrowing, dessication and spondylylosis at L2-3, L3-4 and L4-5. Per a February 25, 2008 note from the provider, the patient's EMG/NCV study did not show a radiculopathy and flexion/extension radiographs showed no instability.

Treatment notes of August 4, 2008 indicate the patient has recent return of left leg pain which was present prior to his L4-5 laminectomy. The pain is not constant but it is sharp and goes into the left foot. He has weaned Roxicodone 30 mg to 6 daily but when his pain worsens he uses up to 9 daily.

On January 14, 2008 the patient reported numbness in the left foot and pain twinges in his back. He does not smoke or drink. He has gained weight. He has night sweats, ringing in the ears, chest pain, high blood pressure, heartburn, black tarry stools, arthritis and diabetes. His MRI shows suggestion of a small disc extrusion at the left L4-5, however he is neurologically intact.

Request was made on February 10, 2009 by a mental health provider for the patient to be seen for psychological assessment and/or treatment with rationale that his pain has extended beyond the primary interventional phase of 0-3 months with continued significant impairment in daily functioning and failure to return to work and/or progress adequately in healthcare treatment. Additionally, there are psychological correlates of affect and stress, sleep disturbance, and persistent, excessive use of health care. Recommendation was for consideration of individual psychotherapy (CBT). Request is for a psychological interview and three hour of psychological testing. The patient's provider has requested he be assessed for appropriateness for individual psychotherapy.

Request for a psychological interview (1 hour) and psychological testing (3 hours) was not certified in review on February 13, 2009 with rationale that the submitted clinical information did not meet preliminary guideline criteria. A peer-to-peer discussion was not realized.

The provider responded on February 22, 2009 with request for reconsideration. A peer-to-peer discussion was not realized despite a message that a call was forthcoming. The review nurse has stated the psychological component is being denied. How can this opinion be made lacking a psychological assessment?

Request for reconsideration of psychological interview (1 hour) and psychological testing (3 hours) was not certified in review on March 4, 2009 with rationale that the most recent clinical note from the provider was illegible. The remainder of the record consisted of several duplicate copies of the request for services, an MRI of the lumbosacral spine and office visit notes dated 2007 and early 2008. The records indicated that "psyche is not a compensable injury on this claim." The medical records failed to document information regarding the patient's mechanism of injury, a comprehensive assessment of treatment to date, or the patient's current psychological status. A visit for psychological testing was determined to not be medically necessary. The patient has not undergone psychological evaluation and therefore testing would not be appropriate at this time.

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

The medical records indicate the patient is status post back surgery on July 10, 2003. He has become symptomatic with left foot paresthesia and was provided neuroplasty for left L4 and L5 lumbar radicular pain, although subsequent nerve studies did not show a radiculopathy. The patient has a variety of health conditions and his MRI shows suggestion of a small disc extrusion at the left L4-5, however he is neurologically intact. A referral for psyche evaluation/treatment was made with rationale of impairment in daily functioning and failure to return to work and/or progress adequately in healthcare treatment and excessive use of the healthcare system.

ODG supports testing such as the MMPI to determine the existence of suspected psychological problems that are comorbid with chronic pain, to help to tailor treatment. Stress testing focuses 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. In talking to the patient, it is important for the physician to get him or her to try and explain or pinpoint incidents or reasons for the stress, rather than to just generalize (i.e. "I hate my job," "Everything makes me stressed out," etc.). The physician may have to ask more specific questions about work or home life if the patient is initially unwilling or unable to address specific issues.

The medical records fail to clarify the patient's psychological status or to identify red flags or warning signs for potentially serious psychopathology that would require immediate specialty referral. The referring provider has the responsibility for first line documentation of relevant history and psychological factors that could potentially be considered comorbid to the patient's chronic pain. Lacking a more comprehensive assessment of treatment to date, or the patient's current psychological status, recommendation cannot be given to support a referral for psychological evaluation and/or testing. Therefore, my recommendation is to agree with the previous non-certification of the request for psychological interview and psychological testing 3 hours.

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines Mental Illness & Stress, updated 2-13-2009:

MMPI:

Recommended to determine the existence of suspected psychological problems that are comorbid with chronic pain, to help to tailor treatment. Not recommended as an initial screening tool for all cases of chronic pain. The MMPI and a revised version, MMPI-2, provide a psychological questionnaire that contains three validity scales and ten clinical scales that assesses the patient's levels of somatic concern, depression, anxiety, paranoid and deviant thinking, antisocial attitudes, and social introversion-extraversion. The instrument, one of the most commonly used assessment tools in chronic pain clinics, can be useful to evaluate which behaviors and expressions related to pain are secondary to psychological stress and which are related to personality traits. The tool has not been shown to be useful as a screening tool for multidisciplinary pain treatment or for surgery. It is not recommended as an initial screening tool for general psychological adjustment in relationship to chronic pain. It cannot be used to corroborate the differential between organic and functional-based pain. Several MMPI profiles have been described in relation to pain patients:

- Conversion V profile: An elevation of scores on the hypochondriasis scale (scale 1, Hs) and hysteria scale (scale 3, Hy), with at least 10 points greater on these scales than on the depression scale (scale 2, D). Evidence of this profile has been interpreted as evidence of a preexisting personality that is a major contributing factor in chronic low back pain, although this is disputed. Elevations of hypochondriasis (scale 1) and hysteria (scale 3) have been found to negatively correlate with return to work.
 - "Neurotic triad": has been coined to describe a cluster of elevated scores of hypochondriasis, depression and hysteria. Evidence has been supportive that these scales are consistently elevated in pain patients, predicting both decreased short- and long-term pain relief. Evidence has also been found to be conflicting as to whether scales 1 and 3 are associated with functional impairment related to pain.
 - PAIN: A clustering of pain scales based on the MMPI that was described by Costello, et al., including the following: P: Nearly all scales are elevated; A: The Conversion V profile; I: The "neurotic triad"; & N: Normal.
- Criteria for Use of the MMPI:

- (a) To determine the existence of psychological problems that are comorbid with chronic pain;
- (b) To help to pinpoint precise psychological maladjustment and help to tailor treatment;
- (c) To garner information that may help to develop rapport and enhance level of motivation;
- (d) To detect psychological problems not discussed in the clinical interview. One particular area that may be helpful is the use of the Addiction Acknowledgement Scale.

Stress - Initial Evaluation:

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.

In talking to the patient, it is important for the physician to get him or her to try and explain or pinpoint incidents or reasons for the stress, rather than to just generalize (i.e. "I hate my job," "Everything makes me stressed out," etc.). The physician may have to ask more specific questions about work or home life if the patient is initially unwilling or unable to address specific issues.

Occupational stress usually stems from one of three common models:

- 1) 1) Person-environment fit model: Poor job fit, such as a mismatch between the skills of the individual and the demands of the job, or a disparity between the individual's career-related desires vs. actual opportunities presented, is a leading cause of workplace stress.
- 2) 2) Demand control model: Jobs that place high demands on the worker but give him or her little control or opportunities for decision-making lead to high job strain, a source of stress that is consistently linked as a contributor to physical conditions such as cardiovascular mortality, heart disease, and hypertension. Consideration should be given to the influence of the individual's occupational and personal history, which may have an effect on how this model applies to his or her situation.
- 3) 3) Effort-reward model: Shows that stress is often the result of high effort without social reward. Like the demand control model, this model points out that a low ratio of effort to reward leads to sustained autonomic arousal and can cause physical effects such as high blood pressure or myocardial infarction.

Exploration of how and if the patient's stress follows the path of one of the above models will be helpful in determining treatment.