



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 11-16-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Psychotherapy 1 x 6

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

Psychologist

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 2-3-06 PAC., Emergency Department visit.
- 2-3-06 x-rays of the lumbar spine.
- 5-17-06 x-rays of the lumbar spine.
- 5-24-06 CT scan of the lumbar spine.
- 6-8-06 Whole body bone scan.
- 8-9-06 MD., performed an evaluation.
- Office visits from MD., through 9-19-09.
- aquatic therapy notes.
- 2-15-08 MD., performed a Peer Review.
- 6-17-09 Individual Behavioral Medicine consultation performed by MS., LPC.
- Individual psychotherapy from 7-29-09, 8-12-09, 8-19-09 and 9-3-09.
- 9-22-09 PhD., performed a Utilization Review.
- 10-19-09 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, the claimant was seen at a local emergency department under the direction of PAC., with complaints of low back pain . He stated the pain was worse after shoveling snow. He also stated that he fell out of his bed. The evaluator reported that the claimant was asking for a narcotic injection, which he refused. He offered a Toradol IM, and the claimant accepted. The claimant requested refill of medications, to include

Valium and Oxycodone, which the evaluator refused. He provided the claimant with a limited supply of Lortab with no refills. The evaluator recommended the claimant get a family physician if he was going to be staying in the area.

X-rays of the lumbar spine dated xx/xx/xx showed post laminectomy changes and fusion L4-S1 approximately 1 cm anterior translation L5-S1.

X-rays of the lumbar spine dated 5-17-06 shows lumbar fusion with very slight spondylolisthesis of L5 on S1. There is some demineralization of the inferior end plate of L5 and the intervertebral graft worrisome for potential infection.

CT scan of the lumbar spine dated 5-24-06 shows L5 spondylolysis with grade I and II spondylolisthesis L5-S1. Suggests abnormal bone graft L5-S1. Possibility of underlying infection versus non-union. There are extensive post surgical changes.

Whole body bone scan dated 6-8-06 was unremarkable.

On 8-9-06, MD., performed an evaluation. It was his opinion that the medical conditions attributed to the compensable injury include failed back surgery, chronic lumbar pain, chronic lumbar radiculopathy, observation for pseudoarthritis lumbar fusion L5-S1. The evaluator found that most of his treatment has medically reasonable and necessary. He also found that some has been excessive particularly in the attempts at rehabilitation in which they were unsuccessful otherwise he found the treatment of his pain was reasonable and necessary throughout this period of time. This was basically care after he had his surgical treatments. The shoveling of the snow and falling out of bed only increased the pain he states he was already experiencing. The shoveling of the snow seemed to be the larger culprit in producing his pain however, he subsequently recovered from both incidents and his pain level is back to where it was prior to those two incidents. He saw no indication that this represents a new injury. His symptoms were all the same and the evaluator would have to say that this was an exacerbation and increase in his pain. The evaluator recommended that he receive pain management maintenance care primarily with oral medication and to see his doctor every 3-4 months for reevaluation and prescription writing. The evaluator did not feel he needs to see a specialist for his oral pain medication but could certainly be administered by a family practitioner. If the family practitioner felt that he required more, he could certainly arrange for a consultation with a pain management specialist as needed. He did not see any indication for surgery and feel that he would be a very poor risk for any type of surgical treatment. He currently has symptom magnification in more than one area and he felt he would be a poor risk with further surgery, which would just add to his failed back surgery. He is taking Oxycontin and this is certainly very strong. He states his pain ranks a 7 on a scale of 0-10, which is pretty high. It would be his recommendation that his treating doctor evaluate him for the possibility of weaning off the Oxycontin and replacing with another narcotic analgesic. The evaluator felt he will require a narcotic analgesic for the rest of his life and if it is too mild, it will not do anything for helping his chronic back pain.

On 2-16-07, Dr. notes the claimant is complaining of pain in the lumbar spine with radiating down the right leg. He also has some numbness and states that this is an occasional problem. His right leg occasionally gives way and he falls down. Dr. referred the claimant for water therapy. The claimant was continued on Lortab and Soma.

Medical records reflect the claimant underwent a course of water therapy at xxx.

On 10-19-07, Dr. reported the symptoms have increased in severity with pain radiating the right leg. On exam, the claimant had tenderness over the left lumbar area. SLR is 60 degrees on the right and 70 degrees on the left. DTR are present bilaterally. Muscle spasms are not present. The claimant was continued on Lortab and Soma and provided a prescription for Requip due to the tremors and movements in his legs.

On 2-15-08 MD., performed a Peer Review. It was his opinion that the effects of the compensable injury have not resolved. In the sense that the patient has attempted treatment, including several surgeries and has been unsuccessful in resolving his symptoms, in fact, has amplified them. Treatment is not related to the original injury but rather to the results of the initial treatment of the original injury, namely, the surgical intervention and subsequent post laminectomy syndrome. The evaluator noted the claimant is on Hydrocodone and Carisoprodol. However, the evaluator recommended the claimant should attempt to wean him down from it with something less strong. The evaluator reported the claimant is now a tertiary care patient. He has chronic pain syndrome, which is stable. He should be seen by his physician every three months.

Medical records reflect the claimant was provided with a diagnosis of post lumbar laminectomy syndrome. The claimant complained of constant pain across the low back, with right leg pain that goes to the toes and this is constant. He reported numbness in the right leg and numbness in the left leg. The claimant continued under the care of MD. He was provided treatment with medications to include Lortab 10/500, Soma 350 mg.

6-17-09 Individual Behavioral Medicine consultation performed by MS., LPC, notes the claimant underwent an initial interview, mental status exam, behavioral observations, pain drawing, and patient's symptom rating scale. Diagnosis: AXIS I: Pain disorder, associated with both psychological factors and a general medical condition, chronic, secondary to work injury, anxiety disorder secondary to work injury. AXIS II: No diagnosis. AXIS III: Lumbar leg. AXIS IV: Primary support group, social environment, economic, occupational and housing problems. AXIS V: GAF current 55, estimated pre injury 95+. The evaluator reported that based upon the information gathered through the initial interview with the office and the patient's emotional presentation and verbal report, the evaluator would determine that the work accident, pain and ensuing functional limitation have caused this patient's disruption in lifestyle, leading to poor coping and maladjustment and disturbances a vast array of areas of functioning. He appears to have a significant pain disorder, anxiety disorder and moderate depression, secondary to his work injury and chronic pain program. He appears to have been

functioning independently prior to the work injury of xx/xx/xx. Since the work injury, the patient has experienced the following: personal physical injury, inadequate social support, inadequate finances, unemployment and change in residence. The evaluator reported the claimant is contending with a complex mixture of a chronic pain syndrome, anxiety/depressive symptoms and many functional problems related to the original work related spine injury. The evaluator felt that his complex mixture of problems would be best served in an interdisciplinary pain rehabilitation program. The evaluator reported that they will attempt to exhaust conservative avenues of care, in accordance with ODG. The evaluator recommended the claimant participate in a brief course of individual psychotherapy, once weekly for four weeks.

Individual psychotherapy from 7-29-09, 8-12-09, 8-19-09 and 9-3-09.

On 9-4-09, MS, LPC., in reviewing the claimant's progress with individual psychotherapy sessions, the patient has benefited from treatment. To begin with, patient has learned how to practice diaphragmatic breathing and relaxation techniques. In addition, he has learned more effective ways to express and manage negative emotions rather than suppressing or denying these emotions. At the present he continues to experience moderate to severe levels of depression, sleep problems and anxiety that continue to pose interruption to his ability to effectively progress to return to work while managing his pain conditions. Continued therapy is necessary to facilitate his additional gains while managing these stressors. Such levels along with the progress the patient has already made in his individual psychotherapy session certainly warrant further psychotherapy to help reduce patient's psychological distress, maintain the gains he has made and assist his overall recovery and return to work goals. Additional sessions are being requested 1 x 6 to help the patient maintain the gains he has made and lower PSRS numbers for sleep, depression, anxiety and anger.

On 9-11-09, Dr. reported the claimant is basically the same with complaints of constant low back pain across the lower back and radicular pain to both legs. The claimant is provided with a prescription for Lidoderm patch.

On 9-19-09, Dr. reports the claimant's symptoms are basically the same. He complains of constant pain across his lower back. He has radicular pain down both legs to the toes on the right. He has constant numbness in the right leg with sensation of burning on bottom of both feet and all toes on both sides. On exam, SLR is positive on the right and left to 60 degrees. DTR are present on the right and left. Muscle spasms are present bilaterally. The claimant has had 4 surgical procedures in the lumbar area. The evaluator provided the claimant a prescription for Lidoderm patch 5%.

On 9-22-09, PhD., performed a Utilization Review. It was his opinion that this is a xxxx old back injury with multiple surgeries and continued pain with limited function. Has been receiving psychiatric treatment at MHMR and was referred to this facility in June. All self reports of symptom 9-10/10 at evaluation in June, but scores only moderate. He was to participate in some Individual sessions prior to a pain program. He has completed 4 sessions with little or no change in targeted areas, there is no change in treatment plan

and it does not appear they are coordinating with his psychiatrist with no increase in psychological medications. No objective personality testing has been performed. Additional sessions are not reasonable or necessary if simply continuing without revision of treatment plan since no signs of functional improvement. Not consistent with ODG. 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). ODG Mental Illness Chapter Psychotherapy for MDP (major depressive disorder). 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 standalone 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 several presentations of MDD.

On 10-19-09 MD., performed a Utilization Review. It was the evaluator's opinion that the medical necessity of the proposed treatment is not supported by the submitted documentation. There is minimal evidence of objective functional improvement after an adequate trial of psychotherapy. Given the psychotropic medications he is prescribed (Lithium and Lexapro), it is unlikely that he just suffers from an anxiety disorder due to work injury. Lithium is typically used for bipolar disorder or for treatment resistant to major depression, but it does not appear that there has been coordination of care with the treating psychiatrist to develop realistic achievable treatment goals or modify his medications despite persistent complaints. Unimodal approaches in pain conditions of this duration are rarely successful, and it appears the program's initial expectation was that he would likely require a multidisciplinary pain program.

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

The claimant has an injury date from xxxx. He has had diagnostics, a bone scan, water therapy, multiple surgeries, medications, and IT. His treatment, per the available records, has been sporadic. The records note that he has been receiving treatment through MHMR for depression and anxiety but it is unclear why IT is just now being requested after so much time has passed since his injury. He has reportedly completed 4 IT with little progress overall noted with no coordination of treatment through his MHMR providers noted. In addition, it is not explained why the IT occurred from 7/29/09 to 9/03/09. It is unclear why the patient is taking Lithium and how this interacts with his current reported symptoms. The treatment summary from the IT notes no change in pain, irritability, depression, and forgetfulness. There is minimal improvement noted in frustration, muscle tension, anxiety, and sleep. In addition, the psychological evaluation notes that IT is requested as prerequisite per ODG prior to requesting CPMP which is not an appropriate rationale for requesting IT. Therefore, the request for psychotherapy 1 x 6 is not established as medically necessary.

ODG-TWC, last update 11-12-09 Pain - 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

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)