

SENT VIA EMAIL OR FAX ON
Sep/17/2009

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/17/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

6 sessions of individual counseling

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 7/9/09 and 8/7/09

6/17/09 thru 7/23/09

12/8/08

Dr. 3/9/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured at work on xx/xx/xx. At the time, he was working for as a , when his foot became stuck in an X-brace, resulting in him falling forward. He continued to work for the next two months, and then was taken off work. Records do not indicate he has since returned to work.

Claimant has received the following diagnostics and treatments to date: X-rays, MRI, EMG/NCV, e-stim, tens unit, chiropractic, physical therapy (active and passive modalities), injections, work hardening, individual counseling, biofeedback, psychological testing, chronic pain program, and medications management. Office note of 3/9/09 shows diagnoses of: low back pain, knee pain, PTSD, s/p history of multiple falls, per patient, and sleep disturbance.

Plan was to prescribe grab bar for toilet and shower, continue medications, and follow-up in one month. Medications prescribed include Ultram, Lyrica, Zanaflex, Cymbalta, and Effexor.

Patient has apparently subsequently been referred for a psychological evaluation to assess appropriateness for individual therapy. On 6-17-09, patient was interviewed and evaluated by Healthcare Systems in order to make psychological treatment recommendations. As a result, patient was diagnosed with 307.89 chronic pain disorder, 311.0 depressive disorder, and 300.0 anxiety disorder, and r/o 309.81 PTSD. Request is for individual therapy 1x6 with short-term goals of: identify and express feelings, and identify and report cognitive distortions to help decrease symptoms of depression, anxiety, and PTSD. Long-term goals are listed as: stabilization of depressed/anxious/irritable mood, development of improved coping skills, and decrease in flashbacks or nightmares.

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

Patient supposedly has a history of PTSD, although this is currently listed as a rule-out in the behavioral evaluation. It is unclear how the PTSD is related to the initial work related fall, and there is no explanation for this anywhere in the eval. Patient has been advanced through the stepped-care approach recommended by ODG, and having completed a pain program, should be at MMI. There is no rationale presented as to why patient would benefit at this time from more of the same intervention when his pain continues to be reported as 9.5/10, and he continues to have elevated BDI and BAI scores. There is also mention in one of the reports of possible bipolar disorder, which is not noted or addressed in the psych eval. Given these difficulties with the case, medical necessity for the requested services cannot be established.

ODG Work Loss Data, 2009, 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](#))

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](#))

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)