

SENT VIA EMAIL OR FAX ON
Dec/07/2010

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Individual Psychotherapy X 6 sessions

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

Board Certified in Physical Medicine and Rehabilitation; Subspecialty Board Certified in Pain Management; Subspecialty Board Certified in Electrodiagnostic Medicine; Residency Training PMR and ORTHOPAEDIC SURGERY

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

Behavioral Health 12/3/09 thru 10/24/10

Dr. 1/27/10 thru 8/3/10

Dr. 1/11/10 thru 6/15/10

IRO Summary 11/23/10

Dr. 2/19/09

Medical Examination 5/14/10

Dr. 10/14/10

11/5/10

Denial Letters 10/14/10 and 11/8/10

Group 1/29/09 thru 11/24/09

PATIENT CLINICAL HISTORY SUMMARY

This is a lady injured in xx/xx/xx. She developed back pain. She has seen several doctors, surgeons and chiropractors. There are comments that the MRI shows minimal spondylolisthesis with disc dessiccations. Dr. reported there was vertebral motion at L3/4 and L4/5 and was contemplating a fusion.

Dr. felt she was a surgical candidate and not at MMI on 10/14/10. Dr. concurred with surgery (11/5/10). . "I have no alternative recommendations at this point."

There was reportedly evidence of a radiculopathy on emgs, but the IRO Reviewer did not see any attached. Dr. performed an IME on 5/14/10 and wrote, "she has every category of the Waddell signs positive." He was concerned about the surgical workup and advised more psychological assessments. There are different neurological reports from absent findings to localized reflex and sensory abnormalities. Treatment included therapies. Ms. noted she had transforaminal trigger point injections at L3/4 on 10/7 and 10/20/09; I presume that these were ESIs rather than trigger point injections. She had 6 sessions of individualized psychotherapy. Her anxiety levels worsened, but the depression, McGill and fear avoidance scores improved. Six additional ones are being considered.

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

There are many conflicting opinions in the reports reviewed as to whether there is or is not a neurological loss. Dr. feels her symptoms reflect spinal instability. Dr. noted the Waddell signs. The latter are often misunderstood to reflect intentional malingering, but are rather signs of psychological issues superimposed on the actual physical findings. She had some but incomplete improvement with the psychological treatments to date. Ms. feels she is improving and needs more. The IRO reviewer is still not clear if she will or will not have surgery. Her report predated Dr. opinion.

The ODG does not specify how much psychological care is appropriate. In Step 3, it cites an intensive program may be needed. Her injury is nearly 24 months old and she is almost eliminated from the chronic pain programs. They in turn recognize their role as an alternative to surgery. Dr. feels surgery will help. Dr. is not sure, and feels backed into a corner. Dr. is strongly reluctant to consider surgery with the psychological issues he saw. These would all support the role for psychological intervention, but not clearly how much. Borrowing from the pain programs which are heavily cognitively based, (4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided. She had 6 sessions. The additional six are justified as an attempt to avoid the spinal surgery.

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](#). ([Otis, 2006](#)) ([Townsend, 2006](#)) ([Kerns, 2005](#)) ([Flor, 1992](#)) ([Morley, 1999](#)) ([Ostelo, 2005](#)) See also [Psychosocial adjunctive methods](#) in the Mental Illness & Stress Chapter. Several recent reviews support the assertion of efficacy of cognitive-behavioural therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). ([Kröner-Herwig, 2009](#))

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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