



CLAIMS EVAL

Utilization Review and
Peer Review Services

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 2-16-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1 x 6 weeks (90806)

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

- DO., office visits on 8-31-09, 11-19-09, and 12-24-09.
- 12-14-09 initial behavioral medicine consultation performed by, LPC-Intern/, MS, CRC, LPC, Clinical Supervisor.
- 11-6-09 MRI of the lumbar spine.
- 12-14-09 addendum note provided by LPC-Intern/, MS, CRC, LPC, Clinical Supervisor.
- 12-23-09, PhD., performed a Utilization Review.
- 1-20-10 Utilization Review performed by PhD.
- 1-20-10 MS, CRC, LPC., provided a reconsideration request.

PATIENT CLINICAL HISTORY [SUMMARY]:

8-31-09 DO., the claimant is a male, who was injured on xx/xx/xx when a 15-20 foot column fell on the claimant's left shoulder, injuring his left shoulder and low back. The column weighed approximately 1,000 pounds or more. He has had persistent left shoulder pain and low back pain since that time. He has had plane x-rays, which do not show any fracture or dislocation. He has not had aggressive physical therapy. He has not had an MRI. He was referred to Injury Clinic for work up and evaluation. Exam of the left shoulder the claimant has decreased range of motion of the left shoulder on flexion, extension, abduction, adduction, internal rotation, and external rotation. He does have a lipoma over his left clavicle, which is preexisting. On the lumbar spine, he has paravertebral spasming and tenderness in the lumbar spine. He has decreased range of motion of the lumbar spine on flexion, extension, and rotation. Lumbar myospasms and myositis. He has a positive bilateral straight leg raising test. The evaluator reported that within the realm of reasonable medical probability, in this medical examiner's opinion, the vector forces produce enough kinetic energy to tear the annulus fibrosis of a lumbar disc, causing herniation into the spinal canal and/or neuroforamen. The evaluator took the claimant off work for 30 days. The evaluator reported the claimant was terminated from his place of employment. The evaluator recommended physical therapy evaluation and treatment, MRI of the lumbar spine, EMG/NCS of the lower extremities. The claimant was provided with a prescription for Tramadol and Lyrica. The evaluator reported consideration for neurosurgical and pain management consultation.

11-19-09, DO., the claimant is seen for follow up of cervical and lumbar sprain/strain and contusions to his left shoulder and right arm, status post an injury on 8-31-09. He has an MRI on his chart that shows degenerative disc disease at L4-5 and a generalized disc bulge with focal annular tear and moderate spondylitic narrowing of both neuroforamina at L4-5. He is complaining of increased numbness, tingling, and dysesthesia in his right upper extremity going into his right shoulder and into his neck. He has not yet had any x-rays or MRI's of his neck. He has not yet had his EMG/NCV testing done. On exam, the claimant has decreased range of motion of the left shoulder on flexion, extension, abduction, adduction, internal rotation, and external rotation. He does have a lipoma over his left clavicle, which is pre-existing. On the lumbar spine: He has paravertebral spasming and tenderness in the lumbar spine. He has decreased range of motion of the lumbar spine on flexion, extension, and rotation. Lumbar myospasms and myositis. He has a positive bilateral straight leg raising test. On the cervical spine, he has paravertebral spasming and tenderness in the cervical spine. He has decreased range of motion of the cervical spine on flexion, extension, and rotation. Cervical myospasms and myositis. He has numbness, tingling, and dysesthesia in his right upper extremity all the way down to his hand. The evaluator reported the claimant is to continue off work. The evaluator requested a neurosurgical evaluation for his back. The evaluator recommended an MRI of the neck and EMG/NCS of the right upper extremity and bilateral lower extremities. The claimant is continued with his medications.

On 12-14-09, the claimant underwent an initial behavioral medicine consultation performed by LPC-Intern/ MS, CRC, LPC, Clinical Supervisor. The claimant was referred for a behavioral health consultation at the directive of his treating physician, D.O. He requested we evaluate Mr. to determine his treatment needs. He specifically asked that we formally evaluate his emotional status and subjective pain to assess the relationship to the work accident and to determine his suitability for progression to some sort of low-level behavioral treatment. The results of the interview are based on the assumption that the claimant provided accurate information throughout the assessment process. Review of records (one hour), diagnostic interview, mental status exam, behavioral observations, claimant symptom rating scale, pain drawing (two hours), and report generation (two hours). The purpose, scope, and objectives of the initial diagnostic interview were discussed at length with the

claimant and he completed an informed consent for those services. The claimant indicates that he sustained a work injury to his cervical, lumbar, and left shoulder on 08/31/09 while performing his customary duties as a Laborer for Vanguard Construction. Per report, the claimant had been employed with the company for approximately 1 year at the time of the work injury. The claimant states that he was working when a 15-20 foot column, weighing approximately 1,000 pounds, fell on his left shoulder. The incident was reported to the Superintendent on the date of injury. He sought treatment at Scott and White and received a sling for his arm and pain medication. X-rays of the left shoulder on 08/31/09 indicated osteoarthritic change at the acromioclavicular joint. An MRI of the lumbar spine on 11/06/09 revealed degenerative disk disease at L4-1-5, multilevel facet osteoarthritis, generalized disk bulge with focal annular tear and moderate spondylitic narrowing of both neuroforamina at L4-1,5. On 11-18-09, an NCV/EMG of the lower extremity was normal. Per report, he is currently receiving physical therapy. Dr. has asked us to assess his suitability for some level of behavioral health care, secondary to observed emotional distress related to pain and injury. Mental status exam shows the claimant appeared to be appropriate for his stated age. He was cooperative throughout the interview. He was oriented times four to person, place, situation, and time. His motor activity, attention, concentration, and speech were all deemed to be normal. His memory for recent and remote events was intact. Intellectual functioning was within normal limits. His mood was dysthymic and anxious. His affect was appropriate to content His thought process was goal-directed. He was not delusional, nor did he hallucinate. He endorsed cognitive distortions, such as making "should" statements. Judgment, insight, and impulse control were all deemed to be fair. No current risk factors were indicated. He appears to have sufficient education and literacy to understand and complete a battery of formalized psychological testing and assessment if indicated. When asked to quantify his symptoms numerically, the claimant reveals the following: irritability and restlessness, 8/10; frustration and anger, 10/10; muscular tension/spasm, 8/10; nervousness and worry, 9/10; sadness and depression, 10/10; sleep disturbance, 10/10; and forgetfulness/poor concentration, 10/10. Diagnosis: Axis I: Adjustment Disorder with Mixed Anxiety and Depressed Mood, secondary to the work injury. Axis II: no diagnosis. Axis III: Injury to cervical, lumbar, and left shoulder-See medical records. Axis IV: Primary support group, social environment, economic, and occupational issues. Axis V: GAF 53 (current). Estimated pre-injury GAF = 85. The evaluator recommended authorization for participation in a low level of individual psychotherapy for a minimum of 6 weeks. The evaluator will expect that this level of treatment will create a very positive response in his physical rehabilitation program and accelerate his recovery while simultaneously resolving sleep disorder and developing a plan to expedite his return to normal sleep functioning. If his symptoms fail to improve with unimodal individual psychotherapy, he may be a candidate for a comprehensive return to work program.

11-6-09 MRI of the lumbar spine showed there is degenerative disk disease at L4-L5 and there is multilevel facet osteoarthritis. At L4-L5, there is a generalized disk bulge with focal annular tear and moderate spondylitic narrowing of both neuroforamina

12-14-09 addendum note provided by LPC-Intern/ MS, CRC, LPC, Clinical Supervisor. Results of the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) reveal the following: The claimant scored 26 on the BDI-II, indicative of moderate depression. He scored 30 on the BAI, indicative of severe anxiety.

12-23-09 PhD., performed a Utilization Review. The evaluator reported that he discussed this case and requested procedure with Dr. The clinical indication and necessity of this procedure could not be established. The mental health evaluation of 12/14 finds impression of adjustment disorder. However, the utilized psychometric instruments (limited to BAI, BDI) are inadequate/inappropriate to elucidate the pain problem, explicate any psychological dysfunction, or support differential diagnosis in this case; and there is no substantive

behavior analysis to provide relevant diagnostic information. Appropriate treatment cannot be based on an inadequate evaluation. There is no documentation, and no other data now provided, of antecedent, specific psychosocial risk factors predictive of a "delayed recovery" or risk of chronicity in this case, thus requiring psychological or behavioral services to prevent, resolve or reduce [Work Loss Data Institute. (2008). Pain. Official Disability Guidelines. Encinitas, CA; Shaw, W. S., et al. (2009). Early claimant screening and intervention to address individual-level occupational factors ("blue flags") in back disability. Journal of Occupational Rehabilitation, 19, 64-80; New Zealand Guidelines Group. (2004). Assessing yellow flags in acute low back pain: Risk factors for long term disability and work loss. Wellington, New Zealand: Author; Turk, D. C. (1997). The role of demographic and psychosocial factors in the transition from acute to chronic pain. In T. S. Jensen, et al. (Eds.), Proceedings of the 8 h world congress on pain (pp. 185-214). Seattle: IASP Press]. The claimant is also progressing in PT; and there is no indication thus far that this will be insufficient to restore adequate functional status. The identified goals of the requested therapy are subjective and psychometric. A change in test scores or other subjective "measures" is insufficient to demonstrate clinically meaningful progress or effectiveness of this proposed therapy [Kazdin, A. E. (2008). Evidence-based treatment and practice. American Psychologist, 63(3), 146-159], and it does not comport with the expectation of achieving "objective functional improvement" from psychological therapy, as required [Work Loss Data Institute. (2008). Pain/Low back. Official Disability Guidelines. Encinitas, CA], thereby rendering a distinct lack of confidence for the requested treatment. The proposed assessment/measurement of progress using putative "pain levels" here is not clinically meaningful. The validity of linear "pain scales" for the assessment and/or evaluation of treatment for persons with benign pain problems has not been established, and objective measurement in this fashion is not possible [ACOEM Guidelines. (2004). Chapt. 6: Pain, suffering, and the restoration of function; AMA. (2001). Pain. Guides to the evaluation of permanent impairment, Fifth Ed. (pp. 565-591)]. Such an approach "... is not clinically helpful for most claimants with chronic pain as these scales are purely subjective and they commence a clinical assessment with a claimant focus on symptoms instead of function." [ACOEM. (2008). Chronic pain. Occupational Medicine Practice Guidelines, 2nd ed.; p. 102] . This proposed focus is more likely to reinforce pain behavior than to provide meaningful information, suggesting that counseling so proposed should be eschewed. Per all the above, the claimant is not an "appropriately identified claimant" for whom psychotherapy is both reasonable and necessary at this time [Work Loss Data Institute. (2008). Pain. Official Disability Guidelines. Encinitas, CA]. Non-approval is recommended.

12-24-09 DO., the claimant is seen for follow up of cervical and lumbar sprain/strain and contusions to his left shoulder and right arm, status post an injury on 08/31/09. He continues to have pain and discomfort. He has had an EMG of his upper extremities on 12/16/09, which is consistent with carpal tunnel syndrome. He has an MRI of his cervical spine, done 12/17/09, which shows a C5-6 disc bulge and a C6-7 bulge as well. He has an MRI of his lumbar spine, dated 11/06/09, which shows an L4-5 disc bulge. He has not yet been seen by the neurosurgeons. He has been referred out. We are waiting for that appointment to be authorized and scheduled. He does have a designated doctor appointment scheduled in the very near future. On exam of the left shoulder, he has decreased range of motion of the left shoulder on flexion, extension, abduction, adduction, internal rotation, and external rotation. He does have a lipoma over his left clavicle, which is pre-existing. On the lumbar spine: He has paravertebral spasming and tenderness in the lumbar spine. He has decreased range of motion of the lumbar spine OR flexion, extension, and rotation. Lumbar myospasms and myositis. He has a positive bilateral straight leg raising test. On the cervical spine, he has paravertebral spasming and tenderness in the cervical spine. He has decreased range of motion of the cervical spine on flexion, extension, and rotation. Cervical myospasms and

myositis. He has numbness, tingling, and dysesthesia in his right upper extremity all the way down to his hand. The claimant was continued with a no work status, pending further diagnostic evaluation. The evaluator also requested a neurosurgical evaluation. The MRI of the neck was reviewed with the claimant. The claimant had EMG/NCS also reviewed. The claimant is to continue with his current medications.

1-20-10 Utilization Review performed by PhD., notes an adverse determination for the requested individual psychotherapy, once a week for six weeks. The evaluator reported that this is an acute injury (4 and 1/2 months old). There is no evidence that these reported psychological symptoms constitute a delay in the "usual time of recovery" from this acute injury, or require the requested treatment. The evaluation does not identify specific behavioral or psychological findings that suggest risk factors for delayed recovery or chronicity. Additional diagnostics (MRI) have recently been recommended. The claimant has recently attended physical therapy sessions and there is no report of "lack of progress" from these sessions. There is no reason to believe that the current active rehabilitation will be insufficient to restore functional status. The request is not consistent with the requirement that psychological treatments only be provided for "an appropriately identified claimant". Based on the documentation provided, ODG criteria were not met. It is recommended that the request for individual psychotherapy x 6 is not reasonable or necessary. The evaluator reported he discussed the treatment goal, treatment history and the claimant's psychological symptoms with Dr. The evaluator recommended non-approval.

1-20-10, MS, CRC, LPC., provided a reconsideration request. The evaluator reported that in the letter of non-authorization, dated 12-30-09, Dr. states, "the clinical indication and necessity of this procedure could not be established. The mental health evaluation of 12/14 finds impression of adjustment disorder. However, the utilized psychometric instruments (limited to BDI, BAD are inadequate/inappropriate to elucidate the pain problem, explicate any psychological dysfunction, or support differential diagnosis in this case; and there is no substantive behavior analysis to provide relevant diagnostic information. Appropriate treatment cannot be based on an inadequate evaluation. There is no documentation, and no other data now provided, of antecedent, specific psychosocial risk factors predictive of a 'delayed recovery' or risk of chronicity in this case, thus requiring psychological or behavioral services to prevent, resolve or reduce...the claimant is also progressing in PT; and there is no indication thus far that this will be insufficient to restore adequate functional status. The identified goals of the requested therapy are subjective and psychometric. A change in test scores or other subjective 'measures' is insufficient to demonstrate clinically meaningful progress or effectiveness of this proposed therapy...and it does not comport with the expectation of achieving 'objective functional improvement' from psychological therapy, as required...thereby rendering a distinct lack of confidence for the requested treatment. The proposed assessment/measurement of progress using putative 'pain levels' here is not clinically meaningful. The validity of linear 'pain scales' for the assessment and/or evaluation of treatment for persons with benign pain problems has not been established, and objective measurement in this fashion is not possible...such an approach ...is not clinically helpful for most claimants with chronic pain as these scales are purely subjective and they commence a clinical assessment with a claimant focus on symptoms instead of function...this proposed focus is more likely to reinforce pain behavior than to provide meaningful information, suggesting that counseling so proposed should be eschewed. Per all the above, the claimant is not an 'appropriately identified claimant' for whom psychotherapy is both reasonable and necessary at this time...non-approval is recommended." The evaluator reported that the BDI-II and BAT are not utilized to establish a diagnosis. The evaluation actually states, "based upon the information gathered through the clinical interview, mental status exam, behavioral observations, claimant symptom rating scale, and pain drawing, the following is a multiaxial diagnosis:" It is unclear why Dr. believes the diagnosis of Adjustment Disorder is based solely

on the BDI-II and BAI instruments. Further, ODG is clear that claimants with high levels of fear-avoidance need the additional support of cognitive behavioral therapy. ODG reports that initial therapy for these "at risk" claimants should be physical therapy, which the claimant has now completed.

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

The claimant has an injury date of xx/xx/xx. He reportedly sustained an injury to his left shoulder and back while lifting at work. He has been terminated from his job, per report. He has had diagnostics, PT, and medications, as well as surgery referrals. He reportedly self-reports his psychological symptoms of distress as high and was diagnosed with an Adjustment Disorder. His BDI is 26 and BAI is 30 and he has elevated scores on the FABQ. He is taking Lyrica and Tramadol. According to the available documentation, it is felt that the claimant's psychological symptoms of distress are impacting his recovery and that he would benefit from coping skills to address his symptoms of distress as well as pain management techniques to cope with his pain more effectively. The previous denials for IT based on the testing used are not substantiated as those tests are actually named in the ODG guidelines. In addition, he is well over six months post injury and continues to reportedly be experiencing significant pain and surgery may be pursued. The available documentation does support an approval of Individual psychotherapy 1 x 6 weeks to address the symptoms noted in the psychological evaluation.

ODG-TWC, last update 2-12-10 Pain – Psychological treatment: Recommended.

Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (Gloaguen, 1998) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. (Pampallona, 2004) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (Royal Australian, 2003) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (Warren, 2005)

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 2010 Cognitive behavioral stress management (CBSM) to reduce injury and illness:

Recommended. Cognitive behavioral stress management (CBSM) has previously been found to reduce fatigue, depression, and cortisol response to heavy exercise training among competitive collegiate athletes and to speed physical and psychological recovery from

surgery. In addition, CBSM has been found to reduce the incidence of injury and illness among competitive collegiate athletes. (Mino, 2006) (Perna, 2003)

ODG 2010 Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:

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)

ODG 2010 Psychological treatment: Recommended based upon a clinical impression of psychological condition that impacts recovery, participation in rehabilitation, or prior to specified interventions (e.g., lumbar spine fusion, spinal cord stimulator, implantable drug-delivery systems). (Doleys, 2003) 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 2nd ed - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superceded by the MBMD following, which should be administered instead], (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 KNOWLEDGBASE
- 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)