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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 06/29/2010

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 Doctor, 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

Individual psychotherapy 6 sessions for 6 weeks

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

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PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient is a male who sustained an industrial injury on xxxxx The patient was reportedly injured when he was unloading extremely heavy insulation material and felt intense pain in the lower back.

The records include an initial interview report from xxxxx from the same facility requesting the current psychotherapy visits. At the time of this visit, it was noted that the patient had a history of seeking psychiatric help. He had been treated with outpatient therapy for 2 sessions. He was then prescribed medications for a mood disorder after his father died. The patient was evaluated and 6 sessions of individual psychotherapy were recommended.

A xxxx individual counseling note indicates that the patient seems to be resigned to his situation and limitations and does not expect much improvement. It was noted that he takes charge of the conversation and is not always concerned about improving his situation. There was an attempt to redirect his focus and improve his desire and motivation to make things better. An August 16, 2005 individual counseling note indicates that the patient continues to be open, honest and very talkative. He has been able to work on reducing his isolation by interacting better with the therapist and family. An August 26, 2005 individual

therapy note indicated that the intern who authored the note observed that the patient appeared less tense after the psychotherapy session.

The patient also underwent chronic pain management psychotherapy sessions in late xxxx and early xxxxx. On January 16, 2006, it was noted that the patient completed 19 of 20 approved chronic pain management psychotherapy sessions. He had shown improvement throughout the entire program and had requested to continue with the program. The therapist was to request additional sessions.

On January 26, 2010, the patient underwent an interview at the same facility that has requested the current treatment. It was noted that the patient's psychophysiological condition has been preventing him from acquiring the level of stability needed to adjust to the injury, manage the pain more effectively, and improve his level of functioning. Mood seemed bland and indifferent at times, and his affect appeared flat, yet congruent to mood. Ten sessions of pain management program were recommended.

On March 2, 2010, non-certification was provided for 10 visits of a chronic pain management program. It was noted that there is conflicting evidence that chronic pain programs provide return to work for injuries beyond 24 months. It was noted that the patient has been on tramadol as early as November 2009 and possible redirection and misuse issues may be of concern in this patient. There was a documented entry dated December 10, 2009 indicating a plan to conduct a urine drug screen. However, official results were not provided for the reviewer's review.

The patient was seen on April 19, 2010 and it was noted that the patient was transferred 4 years ago to the current treating doctor. His sleep is poor due to recurrent pain interruptions. He has undergone extensive diagnostic and therapeutic treatments. All of these interventions have failed to relieve the chronic pain and he continues to have a diminished quality of life. The patient denied using alcohol, tobacco, or illegal drugs. He was taking tramadol and Mobic.

The patient reported that he is no longer interested in the things that he used to be outside the house. He now finds himself avoiding any form of activity that is not necessary for fear of reinjury. He reports feelings of depression and anxiety. The patient was evaluated and diagnosed as follows: Axis I-chronic pain disorder associated with both psychological factors and a general medical condition; Axis II-deferred; Axis III-724.4,756.12; Axis IV-chronic pain, financial struggle, multiple social losses, and problems with family; Axis V-GAF = 60. It was noted that the patient's thought processes were logical and goal-directed and his answers were thoughtful and reflective. Mood seemed bland and indifferent at times. His affect appeared flat, yet congruent to mood. Six sessions of individual psychotherapy to address high levels of stress and depressive symptoms to help the patient increase management of his chronic pain were recommended.

The request was reviewed on April 27, 2010 and a non-certification was rendered. A total of 18 pages were submitted for review. The report noted a behavioral health interview from April 19, 2010 which indicated that the patient was injured while lifting heavy bags of insulation. The patient had been recommended for surgical intervention but had declined the procedure. He reported 4 to 6 hours of sleep per night with interruption secondary to pain and racing thoughts. The patient reported feelings of depression and anxiety as well as frustration, irritability, short temper, muscle tension, inability to relax, fear of reinjury, and increased pain with tension. He was noted to have a GAF score of 60. He was recommended for 6 sessions of psychotherapy to address high levels of stress and depressive symptoms.

The rationale for the non-certification was that there were no objective clinical findings submitted for review to corroborate the patient's subjective complaints. Additional clinical documentation to include psychometric testing scores would need to be submitted for review before appropriateness could be established.

An April 27, 2010 request for reconsideration directed the reader to ODG Pain-Psychological Treatment. The letter also cites the Texas Labor Code and requests a peer-to-peer discussion with the reviewing doctor.

The request was again reviewed on May 4, 2010 and a non-certification rendered. The reviewer's comments were that the patient was injured some 19 years ago. He now reportedly suffers from depression and anxiety at age 65, construed from the

occupational injury 19 years ago. There are no psychometrics to document his current functional status. There is only a GAF score, which is 60, to support the need for the request. There was no mention of any pharmacological intervention. There was insufficient documentation for his behavioral deficits, plus no contemporaneous linked to the occupational event 19 years ago.

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

As noted by previous reviewers, the records continue to fail to document objective evidence of the patient's psychological diagnoses, including the results of recent psychometric testing. The patient underwent a previous evaluation by the same facility in 2005 with subsequent counseling sessions. The records do not conclusively establish that these sessions resulted in long-lasting improvement. The patient has continued treatment for this 1991 injury, which has included extensive physical and psychological management, including ongoing treatment at the facility that has requested the current psychotherapy visits, without long-lasting resolution. This treatment has included at least 6 individual counseling sessions and 19 or more chronic pain management psychotherapy sessions. Although there is a statement that the patient had exhibited improvement throughout the

chronic pain management psychotherapy sessions, this statement was not supported with conclusive objective measures of such improvement. Further psychological treatment would not be expected to result in appreciable benefit. Therefore, my determination is to uphold the previous determination to non-certify the request for individual psychotherapy 6 sessions for 6 weeks.

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

ODG Pain Chapter:
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)

ODG Pain Chapter:

Behavioral Interventions:

Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. 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) See the Low Back Chapter, "Behavioral treatment", and the Stress/Mental Chapter. See also Multi-disciplinary pain programs.

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

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ).

Initial therapy for these "at risk" patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks
- With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)

With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG Mental/Stress Chapter, repeated below.

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)