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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 09/29/2010

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

2-Hour Battery of Psychological testing

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 07-31-09 Thoracic and lumbar MRIs read by Dr.
- 12-21-09 Peer Review from Dr.
- 05-28-10 Thoracic and lumbar MRIs read by Dr.
- 06-14-10 New Patient Office Visit report from Dr.
- 06-14-10 Plan of Treatment - pain management - from Dr.
- 07-13-10 Pre-authorization request for OVs from Dr.
- 07-15-10 Follow Up medical report from Dr.
- 07-16-10 Patient Face Sheet - Case Information from Injury Clinic
- 07-16-10 Initial Behavioral Medicine Consultation and Addendum from Dr. and
- 07-23-10 Psych testing pre-authorization request from Dr.
- 07-29-10 Environmental Intervention report from Dr.
- 07-29-10 Adverse Determination letter from
- 08-18-10 Fax pre-authorization request from, Ph'D
- 08-18-10 Fax pre-authorization request from Dr.
- 08-23-10 Reconsideration resolution letter from
- 09-14-10 Request for IRO from the Claimant
- 09-15-10 Confirmation of Receipt of Request for IRO from TDI
- 09-16-10 Notice to P&S of Case Assignment from TDI
- 09-17-10 Cover sheet with records submitted from
- 09-20-10 Attorney letter from

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male employee who sustained an industrial injury on xx/xx/xx associated with a rollover accident of a truck at which time he was ejected and thrown about 50 feet. His

injuries included, T11 burst fracture, L3 compression fracture, L1, L2, L3, L4 right transverse process fractures, right-sided 2-5 ribs fractures and traumatic brain injury (TBI). He was treated in-patient with a prolonged ICU stay with hemopneumothorax treated during the stay. He was provided in-patient rehab, a TLSO brace and occupational therapy. Vertebroplasty was approved on August 11, 2009. Pre-existing health conditions included possible COPD; the patient is a heavy smoker. He has one kidney.

In March 2006 his provider felt his cognitive functioning was likely at premorbid baseline and no additional neurological treatment recommendations were made. In April 2006 CT scan showed medial fracture of the right clavicle with a little subluxation of the sternoclavicular joint. In June 2006 his shoulder was a concern. He had slight memory problems. He desired to return to driving. Neurophysiological testing of July 2006 showed impairments in memory, higher order reasoning and concentration. He was recommended to be reevaluated at the end of 2006 or early in 2008. By October 2006 he had regained strength and an FCE showed him to be in the heavy work physical demand level. He attended work hardening and was allowed to return to work with no lifting over 75 pounds. In January 2007 he was evaluated for MMI and assigned 31% whole person impairment. The diagnoses noted the closed head injury had resolved, the burst fracture at T11 resulted in greater than 65-70% compression of the vertebral body, the tranverse process fractures at L3 and L4 (prior report of C3, C4 was an error), the medial clavicle fracture and multiple fractured ribs and hemothorax. He was released to normal duty. The patient was treated for back pain in February 2008. He was using e-stim and Restoril and Tramadol. In February 2009 the patient was working as a long-haul trucker. He was always in pain. He continued using Restoril and Tramadol.

In July 2009 the patient was seen for severe low back pain after trying to free his lawn mower from a ditch. X-rays showed an interval fracture of L1 since the prior examination and T11 burst fracture deformity stable.
Thoracic MRI of July 31, 2009 showed suggestion of cord atrophy just cephalad to T6 and chronic compression abnormality of T11. Lumbar MRI of the same date showed an acute compression fracture at L1, with morphology most consistent with a benign etiology.

A peer review was conducted on December 21, 2009. The claimant injured his chest and back in a rollover when he was. A chest x-ray showed evidence for a right pneumothorax and subcutaneous emphysema. CT scan of January 2006 showed fractures of the right L1 through L3 transverse processes. A 35% burst fracture was seen at T11 with 4 mm retropulsion of bone material causing mild canal stenosis. There were also multiple rib fractures and other incidental findings.
Chest CT also showed multiple rib fractures, emphysema, a right posteromedial pulmonary contusion, a distended stomach and the thoracic fractures. A brochoscopy and nasogastric intubation for Dobbhoff tube feeds was performed. The patient's treatment history was summarized as noted above. The question was posed to the reviewer - Is the new L1 fracture related to the original injury? Per the reviewer, the patient is a chronic smoker with likely osteopenia and was lifting a heavy mower and sustained a new injury/fracture. The L1 fracture is unrelated to the activities of.

The patient was examined on June 14, 2010 for medication management. In 2006 the patient was in a rollover accident and sustained an industrial injury to the polytrauma including traumatic brain injury, L3-4 tranverse process fracture, T11 burst fracture, L1-3 transverse process fracture and right ribs 3-6 fracture. He had a prolonged course of ICU stay as well as a hemopneumothorax also treated inpatient. He has been contending with chronic pain primarily localized to the lower thoracic, upper lumbar spine region. In 2009 he was pulling a vehicle (mower with driver seat) out of a ditch and noticed worsened back pain and was found to have a L1 burst fracture. He recently has a neurosurgical evaluation and he was told he is not a surgical candidate. He is using tramadol and Vicodin (5-8 daily) and Restoril. He drives a truck. He smokes ½ to 1 pack daily. He is alert and oriented. He answers questions appropriately. He maintains good eye contact throughout the interview. He has chronic pain syndrome secondary to trauma with known L1 burst fracture and previous L1-3 transverse process fracture after a work related injury sustained in. He is hesitant to use opioid medication for fear of addiction. Vicodin and tramadol were stopped and Percocet and Zanaflex initiated.

Additional medication management office visits were requested on July 8, 2010.

A follow-up medical report dated July 15, 2010 notes two injuries, chronic back pain from injuries of where he had a fracture of T11 and a re-injury in 2009 at home resulting in low back pain secondary to a compression fracture at L1. He has decreased flexion and extension. No muscle spasm is noted. Straight leg raise is negative right and left. He ambulates with difficulty. He will remain off work for 90 days (while using Percocet). He is recommended to undergo a physical therapy evaluation, a psychological evaluation, consider chronic pain management and return in 3 months.

An initial Behavioral Medicine consultation was conducted on July 16, 2010 to determine his treatment needs. The referring provider specifically asked for a formal evaluation of 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. A CT scan of his head on 01/20/06 revealed a small frontal hemorrhagic contusion with bilateral very small hygromas. A neuropsychological assessment was performed on 02/16/06 and a follow-up on 07/11/06. He states he has never been pain free. Imaging of July 2009 showed interval fracture of L1 since the prior exam and a new superior L1 compression fracture. He is using Oxycodone and Temazepam. He rates his pain as 7/10 with intermittent elevations to 10/10. He describes his pain as burning. He sleeps 6 fragmented hours per night. His attention, concentration, motor activity and speech were all deemed to be normal. His mood was apathetic/indifferent. His though content was positive for ruminations regarding his injury. He quantified his symptoms as follows: Irritability and restlessness, 6/10; frustration and anger, 4/10; muscular tension/spasm, 7/10; nervousness and worry, 5/10; sadness and depression, 4/10; sleep disturbance, 4/10; and forgetfulness/poor concentration, 4/10. A diagnosis was provided following examination of Pain Disorder associated with both psychological and a general medical condition, chronic, secondary to

work injury. He is recommended to complete a battery of psychological testing. A formalized battery of psychological tests (2 hours) including a MMPI-2RF are requested, to aid in establishment of individualized treatment goals. Per an Addendum, Beck scores were noted as BDI-II: 4 and BAI: 0, indicating minimal depression and anxiety. His responses on the Fear Avoidance Questionnaire (FABQ) showed significant fear avoidance of work (FABQ-W = 40) as well as significant fear avoidance of physical activity in general (FABQ-PA =24). THE BDI-II and BAI endorsements appear incongruent with the clinical observations. Further testing is warranted.

Psychological testing (2 hours) including MMPI-1-RF was requested on July 23, 2010.

Request for 2-hours of psychological testing was considered in review on July 29, 2010 with recommendation for non-certification. The provider's pre-cert contact was not available for a discussion. The patient's treatment history was summarized. His current medications include oxycodone and Temazepam (Restoril, benzo drug for sleep and anxiety). MRI of July 31, 2009 suggested cord atrophy at T6 and evidence of fractures (T11 burst fracture, L3 compression fracture). Psychological testing was ordered on July 16, 2010. He had a pain level of 7/10, was restless, nervous, depressed and apathetic etc. Testing showed BDI of 4 and BAI of 0, FABQ of 40 and GAF 55. Rationale for denial notes the Peer report indicates the claimant had a new injury to the lumbar spine lifting a lawn mower on with probably resultant L1 fracture possibly abetted by years of smoking and is unrelated to original injury. The claimant has extremely low Beck scores and it is unknown why the current level of evaluation dated July 15, 2010 is inadequate for trial of IT. Given inability to contact provider for discussion, the request is not recommended for certification.

In response an Environmental Intervention was submitted dated July 29, 2010 by the psychologist noting that the denial review was conducted by a chiropractic provider, which would not be appropriate for a request for psychological testing as the service is out of the scope of the chiropractic provider. The request should be reviewed by a psychologist.

Psychological testing (2 hours) including MMPI-1-RF was again requested on August 18, 2010.

Request for reconsideration 2-hours of psychological testing was considered in review on August 23, 2010 with recommendation for non-certification. A peer discussion took place with the attending provider. He was in an
. In 2009 he drove a vehicle into a ditch and sustained a compression fracture of L1. MRI of July 31, 2009 indicated possible atrophy at T6. He was approved for vertebroplasty on August 11, 2009. He reports a pain level of 7/10. His BAI is 0, BDI is 4, GAF is 55 and FABQ is 44. There are two areas of concern: First the claimant has sustained two traumas (2006 and 2009) and there is no clarity as to which one is contributing to his current complaints. The injury is the compensable trauma. It has been more than four years since the work injury and there is no definite way to assess liability. The second is that the claimant's psych scores are not significant enough to warrant the requested testing. Per ODG, psyche evaluations are 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.

Request was made for an IRO.

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

ODG: 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). 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...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…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.

The patient has been MMI since January 2007 with whole person impairment of 31% for injuries of. Prior to the second injury of the patient was being treated for constant chronic back pain. In February 2008, he was using e-stim, Restoril and tramadol; in February 2009 he was working normal duties as a and reported he was always in pain. Following
the incident of the patient has a new compression fracture at L1. He continued driving (while using up to 8 Vicodin daily) and smoking and his chronic pain was noted to be increased. Medications were assessed and he was progressed from Vicodin to Percocet and currently, to oxycodone. He continues to use Restoril. He took off work for 90 days since initiating Percocet. Current work status is not clarified. During the Behavioral Medicine consultation he was noted demonstrate apathetic/indifferent mood. He indicated symptoms of irritability and restlessness (6/10), frustration and anger (4/10), muscular

tension/spasm (7/10), nervousness and worry (5/10), sadness and depression (4/10), sleep disturbance (4/10), and forgetfulness/poor concentration (4/10). He has a Pain Disorder and a battery of psychological testing is recommended including a MMPI-2RF.

First level reviewer was not a psychologist.

Second level reviewer noted concern with two incidents of injury and low Beck scores.

While the patient's Beck scores of BDI- 4 and BAI - 0, appear to indicate minimal depression and anxiety, his FABQ showed significant fear avoidance of work (FABQ-W = 40) as well as significant fear avoidance of physical activity in general (FABQ-PA =24) and the examiners opinion that the BDI-II and BAI endorsements appear incongruent with the clinical observations has merit. The patient is clearly apathetic either from mood or medication effects and does not appear to have completed the Beck questionnaires seriously. Further treatment of physical therapy is being considered and his psychological condition could impact participation in rehabilitation. It is also noted that in June 2010 the patient was hesitant to use opioid medication for fear of addiction and has been progressed to opioid medication. Further testing is warranted.

Therefore, my recommendation is to disagree with the previous non-certification for a 2-Hour Battery of Psychological testing.

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

__X___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

The Official Disability Guidelines 09-08-2010 Pain Chapter: Psychological Evaluations:
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).

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.

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.

Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. 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. Other studies and reviews support these theories.

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 W orkers' 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. 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. Maladjusted childhood behavior is associated with the likelihood of chronic widespread pain in adulthood.

Psychosocial factors may predict persistent pain after acute orthopedic trauma, according to a recent study. The early identification of those at risk of ongoing pain is of particular importance for injured workers and compensation systems. Significant independent predictors of pain outcomes were high levels of initial pain, external attributions of responsibility for the injury, and psychological distress. Pain-related work disability was also significantly predicted by poor recovery expectations, and pain severity was significantly predicted by being injured at work.