

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW: FEBRUARY 14, 2011**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Individual psychotherapy – six sessions

**A 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:

Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx-year-old male who was working when he tripped over some parts and twisted his right knee. X-rays of the right knee were obtained and noted to be unremarkable. He was seen at a clinic on two to three occasions and was treated conservatively with medication only.

On October 20, 2010, the patient was seen for right knee and low back pain and right leg numbness. Due to his injury he had lost his job and his family and was clearly depressed and was in great anxiety. History was positive for generalized stress disorder, rickets and a right knee surgery. On examination, the patient had spasms and tenderness in the right sacroiliac (SI) joint and pain over the right piriformis muscle. There was decreased range of motion (ROM) of the right knee. Physician diagnosed lumbar sprain/strain, right knee sprain/strain, probable internal derangement of the right knee, probable herniated disc at L5-S1 with clinical right lumbar radiculopathy, depression and posttraumatic stress disorder secondary to and causally related to work injury. He suggested

obtaining magnetic resonance imaging (MRI) of the lumbar spine, electromyography/nerve conduction velocity (EMG/NCV), physical therapy (PT) and psychotherapy.

In a behavioral consultation, the patient was diagnosed with pain disorder associated with both psychological factors and major depressive disorder and was recommended participation in individual psychotherapy, and psychotropic consultation. Dr. therefore put up a request for individual psychotherapy for six weeks.

Ph.D., denied the request with the following rationale: *"There is no evidence that these psychological symptoms constitute a delay in the "usual time of recovery" from this acute injury (Work Loss Data Institute, ODG 2010). The patient is experiencing acute pain from the injury {x months old}. Guidelines state that "in patients with chronic pain psychological reactions become the major contributors to impaired functioning". However, with acute pain, "pain is still related to tissue damage" and "is not yet compounded by the motivational, affective, cognitive, and behavioral overlay that is often a frustrating aspect of chronic pain" (ACOEM Guidelines, Chapter 6). This is a new injury (x months old) with acute pain. The patient is actively involved in the continued evaluation and treatment of this new injury. There is no report of lack of progress from the current medical treatments. The patient has recently been approved for continued medical treatment of this injury (PT sessions). Dr. could provide no information concerning the patient's recently approved PT sessions and there is no report of "lack of progress from these sessions. Thus, the request is inconsistent with ODG: "consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone". At this time, there is no reason to believe that the current active rehabilitation will be insufficient to restore the functional status. There is no evidence that these reported psychological symptoms constitute a delay in the "usual time of recovery" from this acute injury, thus requiring the requested treatment. There is no evidence that this patient is "at risk" for delayed recovery. At this time recent suicidal ideations have been reported, but according to Dr., the patient is not currently suicidal and not in need of crisis intervention or psychiatric hospitalization (either of these interventions do not require preauthorization). Requisite acute professional services in response to suicidal gesture or attempt {or ideation which is judged to present imminent clinical risk), including hospitalization, do not require preauthorization. The request is not consistent with the requirement that psychological treatments only be provided for "an appropriately identified patient". 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."*

Psy.D., indicated that the patient was severely depressed and this review should be based on Mental Illness chapter of ODG as it clearly indicates when MDD is present.

EMG/NCV study of the left lower extremity revealed prolonged left sural latency indicating probable trauma or entrapment of the left sural nerve at the ankle. The prolonged tibial latency bilaterally indicated probable trauma or entrapment of both tibial nerves at the ankle.

From November through December, the patient attended 10 sessions of therapy consistent of therapeutic exercises, electrical stimulation and moist hot packs.

On December 7, 2010, the appeal for individual psychotherapy x6 was denied. Rationale: *"The clinical indication and necessity of this procedure could not be established. The mental health evaluation of 10/27/10 finds impressions of Pain Disorder, Major Depression, NOS and Anxiety Disorder NOS. The evaluation is grossly inadequate, given the above premorbid problems (no comprehensive psychodiagnostic testing, adequate history, or behavioral assessment). In addition, Dr. has diagnosed posttraumatic stress disorder (PTSD) (10/21); but there is no comment on this in the evaluation. Appropriate treatment cannot be based on inadequate evaluation, i.e., "Mental health science is primarily categorized by diagnosis, therefore a credible diagnostic formulation is of the greatest importance for evaluation and treatment planning," [Official Disability Guidelines, (2010). Mental illness & stress]. There is no indication that the current physical therapy will be inadequate to restore premorbid or reasonable functional status, i.e., at this time there is no evidence of "lack of progress from PT," as a required indication for psychotherapy in this type of case [Official Disability Guidelines. (2010). Pain]. The proposed goals of the therapy are subjective and abstract only and not individualized to this patient. There are no specific, unique objective or overt behavioral goals proposed for this requested therapy, inconsistent with the expectation of achieving "objective functional improvement" from psychological therapy, as required [Official Disability Guidelines, (2010). Pain/Low back], thereby rendering a distinct lack of confidence for the requested treatment. I am not able to establish a basis that this treatment is both reasonable and necessary at this time. Non-approval is recommended".*

On January 2, 2011, M.D., performed a designated doctor's evaluation (DDE) and deferred assessment of maximum medical improvement (MMI). The patient could not return to any kind of work. In regards to the extent of injury, the records were incomplete and there was no Employer's First Report of Injury; therefore, it was difficult to say what the patient reported at the initial event. The type of injury the patient described was consistent with a low back injury and a knee injury. Therefore the extent of injury was knee sprain/strain with internal derangement and lumbar strain/sprain with an incomplete workup and very possibly lumbar disc disease, unclear if aggravated.

On January 5, 2011, M.D., refilled the Norco and changed Flexeril to Soma.

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

On 10/27/10, patient was referred for a psychological evaluation to assess appropriateness for individual therapy. On 03/25/10 and 04/09/10, patient was interviewed and evaluated by LPC, in order to make psychological treatment recommendations. As a result, patient was diagnosed with chronic pain disorder, anxiety disorder nos, and major depressive disorder, severe without psychotic symptoms, all secondary to the work injury. Results of the testing and interview show that patient is dysthymic and anxious and has contracted not to harm himself as he currently expresses suicidal ideation with no plan. Additionally, he struggles

with pain at an average 8/10 level; pain related decreases in recreational, social, and familial activities; decreased overall functioning to 50% of pre-morbid status and initial and sleep maintenance insomnia.

Patient's BDI was a 53 and BAI was a 40. Patient reported high levels of frustration, anger, nervousness, worry, sadness, depression, muscle tension, and sleep difficulties, since the injury and off-work status. GAF is currently 60 and estimated to be 80 before the injury. Goal is to employ cognitive-behavioral and relaxation therapy to address the above issues. Request is for 6 individual psychotherapy sessions, one time a week for six weeks.

A diagnostic interview with testing and recommendations was requested by the patient's treating doctor, and has been conducted. Patient is in the primary-secondary stages of treatment, and ODG places an emphasis on earlier intervention, before the tertiary stages, especially with regard to patients with chronic pain. ODG promotes early intervention and encourages this minimal level of treatment at this point in order to increase the chances of return to work for this type of patient. The results of the psych interview and testing indicate that patient could benefit from cognitive-behavioral interventions aimed at improving coping skills in order to reduce problems with sleep, anxiety, depression and psychosocial issues. A stepped-care approach to treatment has been followed, as per ODG, and the requested evaluation and sessions appear reasonable and necessary to treat the issues arising from the patient's injury-related pain and off-work status with a goal of increased overall physical and emotional functioning.

#### ODG Work Loss Data, 2010, Texas, Pain chapter

**Psychological Screening; Pain Chapter 2010:** 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 2<sup>nd</sup> 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) MCMII-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](#).

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). (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 2<sup>nd</sup> 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](#)

**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](#))

Education (to reduce stress related to illness): Recommended. Patient education consisting of concrete, objective information on symptom management, including disease and treatment information, has been found to help reduce patient stress, especially when combined with emotional support and counseling. ([Rawl, 2002](#))

<p>Chronic pain programs, early intervention</p>	<p>Recommended depending on identification of patients that may benefit from early intervention via a multidisciplinary approach, as indicated below. The likelihood of return to work diminishes significantly after approximately 3 months of sick leave. It is now being suggested that there is a place for interdisciplinary programs at a stage in treatment prior to the development of permanent disability, and this may be at a period of no later than 3 to 6 months after a disabling injury. (<a href="#">Robinson, 2004</a>) (<a href="#">Gatchel, 2003</a>) (<a href="#">Jordan, 1998</a>) Some early intervention programs have been referred to as “secondary treatment,” and differ from the more traditional, palliative care pain programs by not only the earlier onset of treatment, but by treatment intensity and level of medical supervision. (<a href="#">Mayer, 2003</a>)</p> <p><i>Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach:</i></p> <ul style="list-style-type: none"> <li>(a) The patient’s response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity.</li> <li>(b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis.</li> <li>(c) There is a previous medical history of <a href="#">delayed recovery</a>.</li> <li>(d) The patient is not a candidate where surgery or other treatments would clearly be warranted.</li> <li>(e) Inadequate employer support or evidence of work organizational factors limiting return to work without interventions.</li> <li>(f) Evidence of psychosocial barriers that make return to work unlikely.</li> <li>(g) Loss of employment or evidence of partial disability involving ability to perform only “part-time” work or work with “light-duty” restrictions for greater than 4 months. (<a href="#">Mayer, 2003</a>) (<a href="#">Gatchel, 2003</a>) For general information see <a href="#">Chronic pain programs</a>.</li> </ul>
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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**