



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WCN

CLAIMS EVAL REVIEWER REPORT - WCN

DATE OF REVIEW: 2-7-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 6 sessions over 8 weeks CPT 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

PATIENT CLINICAL HISTORY (SUMMARY):

MD., the claimant was lifting sheetrock when he felt a pop in the lumbar area on the right with pain radiating down the right leg to the foot. He was taken to the ER via ambulance. He had a CT scan. He was given a muscle relaxant and Hydrocodone, which he reports has not helped. The claimant was sent to therapy, which he could not tolerate. On exam, the claimant has 2/4 patellar reflex on the left and 0 on the right. SLR was 20 degrees on the right and 70 degrees on the left. The claimant was given a prescription for Soma, Hydrocodone, Lyrica and Dalmane.

MD., the claimant's medications are working well, as far as covering his pain. The claimant will be seen in a month.

12-15-10 MD., the claimant is working with a definite limp favoring his right side. His medications are covering his pain. He has no new prescriptions.

12-16-10 Initial Diagnostic Screening - Impression: The claimant reported agitation, anxiety, depression, and sleep disturbance symptoms started October 19, 2010. On the Fear Avoidance Beliefs Questionnaire, The claimant scored a 24 on the Physical Sub Scale and a 37 on the Work Sub Scale. This particular score on the physical sub scale is considered "high" and may suggest that the patient is likely to be an "avoider." Furthermore, his score of 37 on the work sub scale reveals avoidance and fears of work situations. On the Patient Pain Drawing, The claimant rated his pain a 9 on a scale from 1-10. He reported pain sensations of aching in his lower back with radiation into his right leg. On the Pain Experience Scale, The claimant scored a 96 (severe-extreme). He reported feeling the following: frustrated, irritable, depressed because of his pain, angry, overwhelmed, thinks "this pain is driving me crazy," feels impatient with everybody, anxious, thinks "it is so hard to do anything when I have this pain", thinks of nothing other than his pain, thinks about his pain getting worse, wonders what it would be like to never have any pain, feels afraid my pain will get worse, feels afraid his pain will get worse, worries about my family, and wonders how long this will last. On the Revised Oswestry Low Back Pain Disability Questionnaire, The claimant scored a 54% (severe). He reported having problems with the following: pain intensity, lifting, walking, standing, sleeping, social life, and thinks his pain is neither getting better nor worse. According to the Beck Depression Inventory, The claimant scored a 22 showing moderate to severe depression. He reported the following feelings: sadness, pessimism, dissatisfaction, irritability, indecisiveness, self-dislike, guilt, sense of failure, body image change, somatic preoccupation, insomnia, and work difficulty. The claimant scored a 10 on the

Beck Anxiety Inventory showing a mild amount of anxiety. He reported the following: fear of the worst happening, terrified, and numbness or tingling. On the Sleep Questionnaire, the claimant scored a 30 (mild). He reported having the following problems: waking up too early in the morning, cannot stop thinking while trying to fall asleep, and cramps, pain, or crawling sensations in legs while lying in bed. He reported that his sleep disturbances are caused or made worse by his physical pain, personal stress, frustration and anger, worries about current injury or re-injury, and cannot stop thinking. He reported having trouble sleeping 5 out of 7 nights and a sleep duration of 8 hours a night. DSM IV: Axis I 309.28 Adjustment Disorder with Mixed Anxiety and Depressed Mood, Acute V62.2 Occupational Problem. Axis II 799.9 Diagnosis Deferred. Axis III 724.2 Lumbar, Axis IV Psychosocial Stressors (PSS) Related to Injury (type) physical health, primary support group/marital, educational/school, occupational/work, housing/living circumstances, economic/financial. Psychosocial Stressors (PSS) Related to injury (severity) 3-4, Moderate to Severe. Axis V Global Assessment of Functioning (GAF) (current), 58, Moderate. Global Assessment of Functioning (GAF)(prior to injury); 78, Average. Treatment recommendations: Individual psychotherapy 6 units.

12-21-10 MS, LPC., letter. Behavioral Health Associates on 12-21-10 requested individual psychotherapy, which was denied on 12-21-10. is appealing this decision which was deemed denied due the following reasons: "the clinical indication and necessity of this procedure could not be established. The mental health evaluation of 12/16/10 finds impressions of adjustment disorder, acute. The evaluation is insufficient, in that it does not... "elucidate the current psychological and behavioral factors which are salient in maintaining the complains and dysfunction ...or...assess the likely premorbid factors which may be contributory." [ACOEM. (2008). Chronic pain. Occupational Medicine Practice Guidelines, 2nd ed; p. 319-320]. There is no documentation of specific antecedent 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 patient is currently working, with temporary restrictions, However, there is no finding of interpersonal problems or behavioral factors limiting functioning on the job which would require psychological services to reduce or resolve. Psychotherapy in this context is inconsistent with the need for "resolution of interpersonal, behavioral, or occupational self-management programs in the workplace, during/after return to work, where such problems are risk factors for loss of work or are impeding resumption of full duty or work consistent with permanent restrictions." There are several items which need to be clarified in addressing this denial. First and foremost, The claimant is not working with temporary restrictions. In the Initial Diagnostic screening on page 3, it states "The claimant reports his supervisor has not shown him support, respect, or understanding through his work injury, He was fired from his job and cannot return." Next, in the Initial Diagnostic Screening performed on 12-16-10, The claimant completed the following assessments: Patient Pain Drawing, Pain Experience Scale, Oswestry low back pain disability questionnaire, Beck Depression Inventory, Beck Anxiety Inventory, and Sleep Questionnaire. The claimant's score on the Beck Depression Inventory was in the moderate to severe category, so the focus should be on the items endorsed. On the Beck Depression Inventory, The claimant reports sadness, pessimism, dissatisfaction, irritability, indecisiveness, self-dislike, guilt, sense of failure, body image change, somatic preoccupation, insomnia, and work difficulty; he scored a 22 on this assessment. The claimant scored in the severe categories on the Patient Pain Drawing (9110), Pain Experience Scale (96), Sleep Questionnaire (30, mild) and the Revised Oswestry Low back pain disability

Questionnaire (52%). From UniMed Page: 20132, Date: 01/27/2011 09:58:24. According to the Official Disability Guidelines (ODG), cognitive behavioral-interpersonal psychotherapy is recommended treatment intervention to treat affective functioning deficits. Specifically, "stress management that includes cognitive therapy has the potential to prevent depression and improve psychological and physiological symptoms is recommended. As with all therapies, an initial trial may be warranted, with continuation only while results are positive." (Minn, 2006) (Granath, 2006) (Siversten, 2006). Also, according to the National Guideline Clearinghouse (2005), in the guideline for the clinical practice guidelines. Additionally, according to National Clearinghouse Guidelines, "Any co-morbid psychological/psychiatric conditions, such as, adjustment issues also need aggressive psychotherapeutic interventions. At the very least, behavioral/psychological therapy needs to include stress management training, relaxation training, cognitive behavioral therapy, and contingency management techniques, The claimant is not taking any psychotropic medications at this time. Further, according to the ODG for injured workers, "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). (Pavkel, 2000) (Bockting, 2006) (DePubeis, 1999) (Goldapole, 2004). Next, literature supports that there are six major patient variables that include social support, problem complexity and chronicity, personality reactivity and coping styles and treatment setting. The claimant would benefit from participation in individual counseling in order to help him cope with his feelings attributed to his work related injury and related stressors in the area of physical health, primary support groups/marital, educational, occupations, housing, and financial as reported and noted in the psychosocial social stressors section on the report on page 5. Lastly, an initial trial of 6 sessions over 8 weeks with evidence of objective functional improvements is appropriate.

12-27-10 PhD., performed a Utilization Review. It was his opinion that the necessity of this procedure could not be established. The mental health evaluation of 12-16-10 finds impression of adjustment disorders, acute. The evaluation is insufficient in that it does not "elucidate the current psychological and behavioral factors which are salient in maintaining the complaints and dysfunction...or...assess the likely premorbid factors which may be contributory." The evaluator reported the claimant is currently working with temporary restrictions. However, there is no finding of interpersonal, behavioral or occupational self management problems in the workplace, during/after return to work, where such problems are risk factors for loss of work or are impeding resumption of full duty or work consistent with permanent restrictions.

1-20-11 PhD., performed a Utilization Review. It was his opinion that There is no evidence that these psychological symptoms constitute a delay in the "usual time of recovery" from this acute injury (Work I-055 Data Institute, ODG 2011). The patient is experiencing acute pain from the injury (2 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 (2 months old) with acute pain. The patient continues to work light duty . ACOEM guidelines note that once a patient has attempted to return to work, interrupting the patient's return to work efforts could create a "system-induced functional disability". If reinforced by environmental, societal or psychological factors, this process can trigger a

habit of thinking: "As long as I have this condition, I won't be able to work, or alternatively, I should not be released to wade (ACOEM guidelines, chapter 5, 2004). This is counterproductive to the patient's current efforts to maintain employment Furthermore, guidelines note that realistic goals for pain patients are "restoration of function and successful reintegration into the workforce", "even though the complete elimination of pain may not be possible" ACOEM guidelines, chapter 6, 2004). The requested treatment could reinforce psychological, environmental and psychosocial factors that promote "chronic pain states" and inhibit recovery (ACOEM Guidelines, chapter 5&6). 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. The request is not consistent with the requirement that psychological treatments only be provided for 'an appropriately identified patient'. Based on the documentation provided, ACOEM and ODG criteria were not met. Therefore, it is recommended that the request for individual psychotherapy x 6 is not reasonable or necessary. The evaluator recommend non-approval, I contacted Dr. who stated she is authorized to discuss this case at 10:30am CST on 1.14-11. Treatment goals, treatment history and the patient's psychological symptoms were discussed. He upheld the adverse determination.

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

THE AVAILABLE INFORMATION HAS BEEN REVIEWED. THE CLAIMANT HAS AN INJURY DATE OF XX/XX/XX. HE HAS HAD DIAGNOSTICS, PHYSICAL THERAPY, AND MEDICATIONS. HE HAS REPORTEDLY BEEN FIRED FROM HIS JOB. ACCORDING TO THE AVAILABLE RECORDS, THIS CLAIMANT IS TAKING LORTAB, SOMA, LYRICA, AND DALMANE. HE WAS GIVEN DIAGNOSES OF ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD, ACUTE AND OCCUPATIONAL PROBLEM WITH A GAF OF 58 ON 12/16/10. HE WAS NOTED TO HAVE A SCORE OF 22 ON THE BDI AND 10 ON THE BAI AND A PAIN LEVEL OF 9/10. HOWEVER, THE MEDICAL NOTES INDICATE THAT HIS PAIN MEDICATION IS WORKING WELL. THERE IS LITTLE DOCUMENTATION ABOUT A COORDINATED TREATMENT PLAN, ANY DECREASE IN MEDICATIONS, OR HOW HE DID IN PT. IT IS NOT CLEAR IF AND/OR HOW HIS DOCTOR HAS ADDRESSED HIS PAIN COMPLAINTS AS THIS WOULD BE THE FIRST LINE OF INTERVENTION PER ODG. BASED ON THE AVAILABLE INFORMATION, THE NECESSITY FOR INDIVIDUAL PSYCHOTHERAPY DOES NOT APPEAR TO BE REASONABLE AND NECESSARY, PER THE AVAILABLE DOCUMENTATION.

ODG-TWC, last update 12-15-10 Occupational Disorders - Pain – Psychotherapy:

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-behavioral 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- 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
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**