CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137

Phone: 817-226-6328
Fax: 817-612-6558

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 19, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Psychological Testing 3 hours to include MMPI-1 & BHI-2

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This physician is Board Certified Physical Medicine and Rehabilitation with over 15 years of experience.

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]:

On xx/xx/xx, the claimant slipped and fell, landing directly on her buttocks sustaining a lumbar injury which resulted in a L1 lumbar compression fracture.

On March 31, 2010, X-rays of the lumbar spine interpreted by MD. Impression: Mild degenerative changes of the lower lumbar spine.

On March 31, 2010, X-rays of the thoracic spine interpreted by MD. Impression: L1 anterior compression deformity, at least subacute in nature. No acute thoracic compression fractures are seen.

On March 31, 2010, the claimant was evaluated at by NP for MD. It was noted she did not undergo vertebroplasty as the procedure was not approved. She did undergo some

conservative treatment measures with therapy and medication. Assessment: L1 compression fracture, diagnosed by MRI in December 2009. The claimant reported her pain had decreased from 10 to 6/10 in her lower lumbar region. The claimant uses methocarbamol 4 times a day. The claimant reported that her ADLs are impaired secondary to the pain. She does have some complaints of thoracic spine pain and x-rays were ordered. May proceed with MRI of the thoracic spine.

On April 19, 2010, X-rays of the lumbar spine interpreted by MD. Impression: Superior endplate compression deformity of L1 of indeterminate age.

On June 9, 2010, the claimant was evaluated by DO. On physical examination she had paravertebral spasming and tenderness in the lumbar spine. She had decreased range of motion of the lumbar spine on flexion, extension, and rotation. She had lumbar myospasms and myositis. Impression: Lumbar sprain/strain, lumbar contusion, L1 compression fracture. Plan: No work for 30 days, physical therapy evaluation and treatment, pain management evaluation and neurosurgical evaluation.

On June 30, 2010, the claimant was re-evaluated by DO. No change in recommendations. Refill of medications included Mobic 7.5 mg and Darvocet N 100.

On June 30, 2010, the claimant was also evaluated by Dr. for the Work Hardening Program. It was noted she had not had epidural steroid injection, vertebroplasty, neurosurgical or pain management evaluations. Plan: The claimant is medically cleared for the Work Hardening Program which is medically necessary.

On July 8, 2010, the claimant had an initial behavioral medicine consultation with MS, LPC-Intern and MS, CRC, LPC. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition, chronic, secondary to the work injury. Axis II: no diagnosis. Axis III: Injury to low back-see medical records. Axis IV: Primary support group, social environment, economic, and occupation issues. Axis V: GAF=65 (current), Estimated pre-injury GAF=80+. Recommendations: All the information obtained through the clinical intake suggests the claimant is having difficulties with her injury and circumstances. She appears emotionally suited to move to a more intensive phase of treatment, which incorporates multidisciplinary approaches to her care. She demonstrated mild disturbances in mood related to the injury and associated psychosocial stressors. She would benefit from supportive psychotherapeutic intervention, and should respond well to a group setting. She would be well suited for a multidisciplinary work hardening setting.

On July 8, 2010, the claimant underwent a Functional Capacity Evaluation by DC. Based on the results she was able to work at the Sedentary Physical Demand Level. Job PDL level is Medium. The results suggested she may benefit from a Work Hardening Program.

On July 26, 2010, the claimant was evaluated by MD. It was reported that the claimant localized her pain primarily in the upper aspect of the lumbar spine at approximately the

L1 level with radiation of symptoms into the thoracic cage radiating into the posterior lateral as well as anterior aspect of the thoracic cage in a T12 distribution as well as radiation of pain from the low back extending into the right hip and into the anterior and medial aspect of the right thigh not extending beyond the knees. Her pain was rated a 6/10. On physical examination straight leg raise was positive on the right wit provocation of right low back pain. There was significant tenderness to palpation along the upper lumbar paraspinous muscles as well as lumbosacral paraspinous muscles from the L1 through L5 levels right greater than left. Sensory, motor, and reflexes were normal. Diagnosis: Compression fracture, lumbar, closed. Assessment: A xx-year-old female with chronic persistent pain consistent with lumbar radiculopathy in a T12-L1 distribution with know L1 compression fracture. Plan: A trial of epidural steroid injection by transforaminal approach at the L1 level. Initiation of Lyrica 50 mg. Discontinue Darvocet and initiate trial of Vicodin 7.5/500. Continue methocarbamol as prescribed by Dr. Continue self-directed physical therapy.

July 28, 2010 through August 13, 2010, there are many Psychotherapy Group Notes from Treatment Center during this time frame.

July 28, 2010 through August 13, 2010, there are many Work Hardening Daily Notes from Treatment Center during this time frame.

On August 12, 2010, the claimant underwent a Functional Capacity Evaluation by DC. Based on the results she was able to work at the Sedentary-LIGHT Physical Demand Level. Job PDL level is Medium. The results suggested she may benefit from a Chronic Pain Management Program.

On August 27, 2010, by MD. Dr. opined that the claimant had obtained maximal medical improvement on August 27, 2010 with a 5% whole person impairment.

On October 25, 2010, the claimant was re-evaluated by DO. On physical examination she had paravertebral spasming and tenderness in the lumbar spine on flexion, extension, and rotation. She continued to have lumbar myospasms and myositis. Plan: She was continued on light duty and her Darvocet N 100 was refilled.

On February 16, 2011, the claimant was re-evaluated by DO. It was noted she was doing the same and scheduled to see a neurosurgeon.

On March 16, 2011, the claimant was re-evaluated by DO. Plan: No work for 30 day pending approval for the chronic pain management program. Proceed with neurosurgical evaluation. Continue Mobic 7.5 mg and Norco 5/325. Consider lumbar CT myelogram.

On April 11, 2011, the claimant was evaluated at P.A. by MD. On physical examination lumbar range of motion was decreased in forward flexion secondary to body habitus and pain. Motor exam was 5/5 strength throughout. Deep tendon reflexes were 2+ throughout and symmetrical. Sensory exam revealed no hypoesthetic region to pin

prick and light touch. Impression: Lumbar compression fracture of L1 neurologically intact, lumbar disc displacement, lumbar radiculitis, and lumbago. Recommendations: I do not feel she is a surgical candidate at this time. She would benefit from evaluation for epidural steroid therapy and chronic pain management therapy program.

On April 20, 2011, the claimant treatment was transferred to MD. She was referred for a pain management consult for ESIs.

On May 20, 2011, the claimant was re-evaluated by MD. Second MRI requested to assess fractured vertebra since she was having ongoing pain.

On June 23, 2011, the claimant was re-evaluated by MD. Recommendation of a psychological evaluation for increasing symptoms of depression.

August 12, 19, & 22, there are individual psychotherapy notes from of Waco.

On August 23, 2011, the claimant was evaluated for chronic pain management program at Injury 1 of Waco by MS, CRC, LPC. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition, chronic, secondary to the work injury. Axis II: no diagnosis. Axis III: Injury to low back-see medical records. Axis IV: Occupational, Economic. Axis V: GAF=67 (current), Estimated pre-injury GAF=95+. Recommendations: They concurred with Dr. recommendation that she participate in a Chronic Pain Management Program as she had exhausted conservative treatment yet continued to struggle with pain and functional problems.

On September 15, 2011, MD performed a UR on the claimant. Rationale for Denial: It appears the claimant has undergone psychological testing in the past to qualify the claimant for chronic pain management program which was not approved. The evaluation and program are being requested again. It is unclear if another psychological evaluation needs to be accomplished as the claimant has previously undergone an evaluation in the past. The claimant has undergone significant psychotherapy. Records do not reflect support for a repeat psychological evaluation.

On September 23, 2011, PhD performed a UR on the claimant. Rationale for Denial: Her latest psychological evaluation was on 7/19/11 and she completed psychotherapy on 8/22/11. The report from 8/23/11 notes that she has a depression score of 12, anxiety score of 9, pain level of 7/10, and some fear avoidance issues. She is taking hydrocodone and Celexa. She has now been recommended for participation in a chronic pain management program. Dr. reported that the only issues noted following psychotherapy are that she may be minimizing her scores and they need the testing “to see if she is candidate” for chronic pain management program. Without outstanding issues of concern and given that the provider has already worked with this patient, the necessity for three hours of psychological testing is no reasonable and necessary.

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

Agree/Uphold denial of Psychological Testing 3 hours to include MMPI-1 & BHI-2. Submitted information documents recent psychological evaluation, testing and treatment sufficient in quest for Chronic Pain Management. Therefore additional psychological testing is not medically necessary.

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). (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) Maladjusted childhood behavior is associated with the likelihood of chronic widespread pain in adulthood. (Pang, 2010) 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. (Clay, 2010) 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 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)