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Notice of Independent Review Decision

DATE OF REVIEW: 04/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 hour Diagnostic Interview 90801
2 hours Mental Health Testing 96101

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

Board Certified Psychiatrist

REVIEW OUTCOME:

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

Upheld (Agree)

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:

1. Cover sheet and working documents
2. Court decision and order dated 05/23/11
3. Mental health evaluation/treatment request dated 02/17/12
4. Referral form dated 02/17/12
5. Mental health evaluation goals/plan/justification
6. Office evaluation dated 01/17/12
7. Utilization review determination dated 02/27/12, 03/22/12
8. Response to denial letter dated 03/09/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient slipped and fell while transferring a patient from a wet shower to a wheelchair. The patient complained of pain in the left leg and low back. The patient was subsequently diagnosed with an ankle fracture and underwent surgery in August 2009. A previous designated doctor reportedly determined that the patient reached MMI as of 01/29/10 with 0% impairment rating. He concluded the lumbar spine and left knee were not compensable. A decision and order dated 05/23/11 concluded that the compensable injury does not extend to include the lumbar spine and left knee. Office evaluation dated 01/17/12 indicates that the patient describes pain as sharp, shooting, throbbing and burning at times. In the past she has been seen by various doctors and provided with medications consisting primarily of Tramadol, occasionally Celebrex and Ambien. The patient was referred to M.D. to help with her pain medication management only. Plan is to refill her medications, follow up for therapy with Dr. and the patient will be seen on an as-needed-type basis.

Initial request for 1 hour diagnostic interview 90801 and 2 hours mental health testing was non-certified on 02/27/12 noting that the rationale for the request is not stated. There is no documentation of any psychological problems. The psychological evaluation is typically recommended prior to initiation of work hardening or pain management program. Response to denial letter dated 03/09/12 notes that Dr. has referred the patient for a multidisciplinary chronic pain management program to address her ongoing physical complaints as well as to address any psychosocial stressors which may be hindering her from full recovery as it relates to returning back to employment. The denial was upheld on appeal dated 03/22/12 noting that Ms. reports that she has not yet been seen; she is a referral. They did an initial behavioral interview without testing in 2010, and the patient was lost to follow up. The patient has a fourth grade education from Mexico. She is primarily Spanish speaking. They do utilize a Spanish speaking therapist. They will assess this patient using MMPI and BHI measures. In the request for services, appeals letter, a checklist of symptoms is enclosed from Dr. with his signature stamp affixed. After this discussion, it was felt that this patient does not qualify for further diagnostic testing per ODG guidelines. Her absence from treatment/noncompliance after the first behavioral workup remains unexplained. She is well outside the mandated 2 year window for such services.

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

Based on the clinical information provided, the request for 1 hour diagnostic interview 90801 and 2 hours mental health testing is not recommended as medically necessary, and the two previous denials are upheld. The issues raised

by the appeal reviewer have not been addressed. The patient reportedly underwent initial behavioral interview in 2010; however, this report is not submitted for review. The patient was then lost to follow up. There is a noncompliance issue that has not been addressed. There is no comprehensive assessment of recent treatment completed to date or the patient's response thereto submitted for review. There is no documentation of any psychological issues in the submitted records. The patient has been recommended for diagnostic interview and testing to determine her appropriateness for a chronic pain management program; however, the patient sustained injuries approximately 3 ½ years ago, and the Official Disability Guidelines note that chronic pain management programs are generally not supported for patients who have been continuously disabled for greater than 24 months as there is conflicting evidence that these programs provide return to work beyond this period. Given the current clinical data, the request is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Psychological evaluations:

Recommended. 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. 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 - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory, (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) See also Psychological evaluations, SCS (spinal cord stimulators) & the Chronic Pain Chapter.

Psychological testing. This supplements information provided in the clinical interview and, at the minimum, should evaluate personality style and coping ability. At least one test should contain validity scales. The current “gold standard” is the Minnesota Multiphasic Personality Inventory (MMPI, or a second version, the MMPI-2). MMPI scores of concern are findings of elevated neurotic triad scores (scales 1,2, and 3; also defined as hypochondriasis [Hs], depression [D], and hysteria [Hy], or a Conversion V score [elevations of scales 1 and 3 at least 10 points above scale 2]). See Minnesota multiphasic personality inventory (MMPI). Other tests have included the Spielberger State-Trait Anxiety Inventory (STAI), Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Hospital Anxiety and Depression Scale (HAD), Millon Clinical Multiaxial Inventory (M-CMI-II), Symptom Checklist-90-R (SCL-90-R), Behavioral Analysis of Pain, Chronic Illness Problem Inventory (CIPI), McGill Pain Questionnaire (MPQ), Coping Strategies questionnaire (CSQ), and Pain Beliefs and Perception Inventory (PBPI).

Post-evaluation, three general categories of patients have been identified:

- Group 1: Patients with no contraindications for implantation
- Group 2: Patients who have a high likelihood of failure. Falling into this category does not mean that an implantable should not be used, but that contraindications should be treated prior to this intervention.

The following are current suggested exclusionary criteria for the use of an implantable pain treatment (Nelson, 1996): (a) Active psychosis; (b) Active suicidal ideation; (c) Active homicidal ideation; (d) Untreated or poorly treated major depression or major mood disturbance. Depression in and of itself in reaction to chronic pain does not disqualify a patient from implantable treatment, although moderately severe to severe depression should be treated prior to trial. Anxiety/panic disorder should also be stabilized; (e) Somatization disorder or other somatoform disorder involving multiple bodily complaints that are unexplained or exceed that could be explained by the physical exam; (f) Alcohol or drug dependence (including drug-seeking behavior and/or uncontrolled escalated use) See Opioids, red flags for addiction; (g) Lack of appropriate social support; (h) Neurobehavioral cognitive deficits that compromise reasoning, judgment and memory.

Other “red flags” include: a) unusual pain ratings (for example, the pain rating never changes from 9-10); b) unstable personality and interpersonal function; c)

non-physiological signs reported on physical exam; d) unresolved compensation and litigation issues.

- Group 3: Patients who may require brief cognitive and/or behavioral intervention prior to the trial. These have also been referred to as “yellow flag” patients. The following are factors that have been found to increase the risk for a poor outcome: (a) Mild to moderate depression or anxiety; (b) Somatization disorder in the presence of medically explained pain; (c) Hypochondriasis if the focus is on something other than pain; (d) Mild to moderate impulsive or affective disorder; (e) Family distress/dysfunctional behavior; (f) Social distress/dysfunctional behavior; (g) Job distress/dysfunctional behavior. There is no good research as to what patients fall into this group. Treatment duration has been suggested according to severity of symptoms, with a general suggestion of approximately 6 sessions. Williams has suggested that this therapeutic intervention should include: a) education; b) skills training (training for a variety of cognitive and behavioral pain coping skills including relaxation training, activity pacing, pleasant activity scheduling, problem solving, and sleep hygiene); and c) an application phase to apply the above learned skills. (Doleys) (Beltrutti, 2004) (Gybels, 1998) (Prager, 2001) (Williams, 2003) (Monsalve, 2000) See also Psychological evaluations (above), plus Spinal cord stimulators (SCS) & Intrathecal drug delivery systems (IDDS) in the Pain Chapter.