

AccuReview

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: April 19, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual psychotherapy 1 x 6 weeks

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

The Reviewer is a Board Certified Psychologist with over 24 years of experience.

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:

01-24-12: Referral Form for Psychological Testing and Individual Counseling from
03-09-12: Psychological Assessment Report by
03-12-12: Behavioral Health Individual Psychotherapy Preauthorization Request from
03-15-12: UR performed by
03-26-12: Reconsideration: Behavioral Health Individual Psychotherapy
Preauthorization Request by
04-02-12: UR performed by

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the limited records sent for review, the claimant is a male who was injured on xx/xx/xx. The claimant reported that the control malfunctioned, jerked, and twisted

him while he was still holding onto the load. He felt a “rip” in his back. He was seen by the company doctor who performed x-rays and placed him off work for a week. On October 4, 2011 he had a MRI of the lumbar spine which revealed a L4-5 and L5-S1 mild broad based disc bulge and facet arthrosis. He also had a MRI of the pelvis which revealed an L5-S1 4 mm paracentral disc protrusion with post annular tear that contacts the S1 nerve root. The claimant received treatment in the form of conservative care, ESI and work hardening.

03-09-12: The claimant underwent a Psychological Assessment by at the request of to assess his emotional status and to determine the relationship to the work accident. Current medications: Cymbalta 60 mg, Hydrocodone 7.5/500 bid, and Soma 350 mg. The claimant self-rated pain level was a 7/10. He described the pain as aching and stabbing pain in his low back that radiates down into his right leg. The claimant reported difficulty with acts of daily living including: self-grooming, household chores, caring for children, exercising/playing sports, driving, sitting more than 15 minutes, standing more than 15 minutes, walking more than 15 minutes, bending, squatting, lifting/carrying items more than 10 pounds, climbing stairs, and sexual activity. The claimant reported his level of overall functioning prior to the injury as 100% and his current level of overall functioning as 0%. The claimant described changes in relationships as more conflict with family, less involved in family activities, isolated from others, and less participation in social activities. He also described changes in self-perception, such as a loss of self-confidence, feelings of helplessness, a burden on others, feeling a lack of control over his life, feeling disappointed and angry with himself. He endorsed both initial and sleep maintenance insomnia. It was reported that the claimant was currently not working, however, his employer wanted him to start working with restrictions for two hours a day, but his contract was still being negotiated. The claimant scored 32 on the BDI-II, indicating moderate depression. He scored a 23 on the BAI, reflecting moderate anxiety. His response to the Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work (FABQ-W = 42) as well as significant fear avoidance of physical activity in general; (FABQ-PA = 24). MMPI-2-RF Interpretation: protocol was valid. However, he endorsed some level of infrequent responding that may occur in individuals with genuine, severe psychopathology who report credible symptoms. With that caution noted, scores on the substantive scales indicate somatic and cognitive complaints, and emotion and interpersonal dysfunction. Multiaxial Diagnosis: Axis I: Pain Disorder associated with both psychological and general medical condition, chronic. Major Depressive Disorder, single episode, severe w/o psychotic features. Axis II: no diagnosis. Axis III: Injury to low back. Axis IV: Primary support group, economic problems, occupation problems. Axis V: GAF: current 59; estimated pre-injury: 85+. Recommendation/Summary: It was determined that the work accident pain and ensuing functional limitations have caused this patient's disruption in lifestyle, leading to poor coping and maladjustment and disturbances in sleep and mood. all feel that this patient needs psychological testing prior to requesting a discogram. The psychological testing performed suggested Mr. Ortega provided an unusual combination of responses, suggesting that for individual with no history or current corroborating evidence of psychopathology his endorsements very likely indicates over-reporting psychopathology, but not somatic symptoms.

Indeed, his credible reporting of somatic and/or cognitive symptoms is within average for his comparison group of forensic disability claimant men. It is my professional opinion that clinical presentation is credible and within of what it is expected for his comparison group. He does not have any psychological impediment to pursue the recommended discogram. Additionally, the results of this psychological testing suggests that would greatly benefit from a brief course of individual psychotherapeutic intervention using CBT techniques to facilitate a healthy adjustment and improve his coping with his overall condition by using basic relaxation techniques. The patient should receive immediate authorization for participation in a low level of individual psychotherapy for a minimum of 6 weeks.

03-12-12: Behavioral Health Individual Psychotherapy Preauthorization Request from

03-15-12: UR performed by. Reason for Denial: The clinical indication and necessity of this procedure could not be established. The mental health evaluation of 3/9/12 finds impressions of pain disorder and major depressive disorder. However, the psychometric assessment (see below) was problematic; and there is no substantive behavior analysis to provide relevant clinical/diagnostic information. I reviewed the obtained MMPI-2-RF in detail. In my opinion, the claimant produced a patently invalid test performance. However, there was no follow-up assessment or investigation bearing on why this occurred. Ruling out problematic test taking behavior vs. malingering vs. significant psychopathology is a critical part of a psychological assessment where a patently invalid MMPI-2 is produced and disability support is being sought or provided. There are no randomized controlled trials or other high quality evidence supporting the use of unimodal psychotherapeutic techniques in producing reliable functional improvements and/or reduction of disability with this type of chronic benign pain syndrome; and the above evaluation does not provide evidence that an exception should be made in this case. had requested the psychological evaluation for clearance to pursue a discogram; and the above evaluation finds no "psychological impediment" to that procedure. However, I could find no basis for this conclusion in the report; and now endorses that the patient is merely cleared to undergo the procedure, and there is no assessment with respect to whether the patient may be a candidate for a false positive injection, which is the purpose of conducting such evaluation. It is unclear if will continue to pursue a discogram based on the submitted report; but in any case, psychotherapy is contraindicated during this interval. Per all the above, the patient is not an "appropriately identified patient" for whom psychotherapy is both reasonable and necessary at this time.

04-02-12: UR performed by. Reason for Denial: A discogram has recently been recommended and a "pre-surgical" evaluation on 03/09/12 "cleared" the patient for the surgery. The evaluation concluded that "he does not have any psychological impediment to pursue the recommended discogram". Nevertheless, individual psychotherapy is now being requested. Additionally, the pre-surgical evaluation noted "over-reporting" of psychological symptoms. However, there was no follow-up assessment or investigation bearing on why this occurred. Ruling out problematic test taking behavior vs. malingering vs. significant psychopathology is a critical part of a

psychological assessment where an apparent invalid MMPI-2 with over-reporting of psychological symptoms is produced and disability support is being sought or provided. Furthermore, the patient's presentation is consistent with a chronic pain syndrome and a Pain Disorder is diagnosis. ACOEM guidelines state: "There is no quality evidence to support the independent/unimodal provision of CBT [cognitive behavioral therapy] for treatment of patients with chronic pain syndrome". "There is no known effective psychotherapeutic treatment for such disorders (somatoform, mood, or anxiety disorders), per se, when the etiology of symptoms involves a chronic benign pain syndrome" [ACOEM Guidelines (2008). Chapt. 6: Chronic pain; p. 227]. This request also is not consistent with ODG and ACOEM Guidelines concerning the use of individual psychotherapy with this type of patient who is reporting chronic pain. ODG (for chronic pain) states "consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone". At the present time, there are no current or recent PT sessions and surgery apparently is pending. These issues indicate that the request is not consistent with the requirement that psychological treatments only be provided for "an appropriately identified patient".

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

The previous adverse determination is upheld. Questions concerning the psychological testing: validity, possible malingering, lack of follow-up psychological testing, as well as, a lack of psychological testing to rule out the possibility of an axis II diagnosis (OMNI or MCMI), which might clarify the possible existence of pre-accident psychopathology. ACOEM and ODG guidelines are inconsistent with the request for six individual Psychotherapy sessions: "There is no known effective psychotherapeutic treatment for such disorders (somatoform, mood, or anxiety disorders), per se, when the etiology of symptoms involves a chronic benign pain syndrome" [ACOEM Guidelines (2008). Chapt. 6: Chronic pain; p. 227] and ODG (for chronic pain) states "consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone". The request for Individual psychotherapy 1 x 6 weeks is not found to be medically necessary.

Per the ODG Guidelines:

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](#). ([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-behavioural therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). ([Kröner-Herwig, 2009](#))

ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:

Screen for patients with risk factors for [delayed recovery](#), including fear avoidance beliefs. See [Fear-avoidance beliefs questionnaire](#) (FABQ).

Initial therapy for these “at risk” patients should be [physical therapy](#) for [exercise](#) instruction, using a cognitive motivational approach to PT.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks

- With evidence of objective [functional improvement](#), total of up to 6-10 visits over 5-6 weeks (individual sessions)

With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG [Mental/Stress Chapter](#), repeated below.

ODG Psychotherapy Guidelines:

- Initial trial of 6 visits over 6 weeks

- With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Extremely severe cases of combined depression and PTSD may require more sessions if documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials. Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders.

([Leichsenring, 2008](#))

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)**