



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 5-14-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Psychotherapy 1 x 6 weeks (6 sessions)

**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

- 7-25-11 MD., performed a Peer Review.
- 8-19-11 MD., office visit.
- 11-1-11 MD., office visit.
- 11-17-11 MD., performed a Peer Review.
- 12-8-11 MD., performed a Doctor Selected by Treating Doctor Evaluation.
- 1-6-12 MD., performed a Designated Doctor Evaluation.
- 1-30-12 DC., PhD., performed a Peer Review.
- 4-10-12 MD., office visit.
- 4-10-12 MA, LPC., Initial interview.
- 4-19-12 UR adverse determination. PhD.
- 4-23-12 Request for reconsideration from DC.
- 4-30-12 UR Adverse determination. PhD.

PATIENT CLINICAL HISTORY [SUMMARY]:

7-25-11 MD., performed a Peer Review. Based on the MOI, the initial presenting symptoms, the interval history, and pertinent positive physical exam findings (or lack thereof), the most medically probable work-compensable diagnosis is: left lateral ankle soft tissue sprain; and multiple minor bone contusions. The distal posterior tibial tendon hypertrophy is unrelated to the MOI; it is most medically probably a chronic condition, perhaps related to pes planus. He reviewed multiple digital images of this study and generally concurs with the impression of the radiologist. The soft tissue edema and the bone marrow contusions are related. The posterior tibial tendon hypertrophy is not, as discussed above. Any other finding would be unrelated. Typical conservative measures include rest, ice, and elevation, followed by PT focusing on proprioceptive rehabilitation.

Initial use of a fracture boot may be indicated if there is a large amount of swelling, to be followed by functional bracing with a stirrup splint. An ankle MRI may be indicated if there is concern for AVM OCD, occult fracture, tendon tears, or syndesmosis injury. Early MRIs are typically not necessary to evaluate ligament injuries, but may be useful if persistent instability is demonstrated. Recovery timeframes may be variable and may be relative to the degree of injury. NSAIDs and pain medications would be indicated for the first four to six weeks after the DOI.

8-19-11 MD., the claimant returns for follow up of ankle injury. See previous note. The date of injury was xx/xx/xx, two months ago, left ankle sprain. Initial x-rays were negative and x-rays here on July 25th were negative for fracture. She is better. Using an ankle brace. States that after two hours she has some pain. She was not sure she could return to work. I told her it had been two months since the injury. Clinical exam of the ankle shows no swelling. No instability. Neurovascular status is intact. Plan: His recommendation would be to try to return to work. If she has problems, he will be happy to see her back. He might move toward an MRI of the ankle and/or foot. He recommended that she return to regular work without specific restriction and if she has some significant difficulty, he will take another look at it. He felt she is nearing maximum medical improvement and an impairment rating could be set up.

11-1-11 MD., reported that the claimant's diagnosis is sprains and strains of the ankle. The claimant needs to be sent for MMI and impairment rating with a Designated Doctor. The ankle sprain should have been healed a long time ago.

11-17-11 MD., performed a Peer Review. He noted that the additional information does not alter my previous medical opinion. The most medically probable work-compensable diagnosis remains: a lateral left ankle soft tissue sprain; and multiple minor bone contusions. By now, it would be anticipated that she could walk normally without an assistive device or bracing. The occasional limping noted on the video is probably habitual, and not related to any functional deficit. Pes planus means "flat foot." It is basically a hyperpronation deformity of the foot. It is considered a variation of "normal" in most circumstances. It can lead to chronic problems, like posterior tibial tendinopathy, as was identified on the MM. It is a pre-existing condition—it is not related to the work-compensable claim in any way.

12-8-11 MD., performed a Doctor Selected by Treating Doctor Evaluation. She certified that the claimant had reached MMI on 8-30-11. If she ever produces the records from the unknown other doctor who stated that she needed surgery and if that surgery is found to be related to the work injury of xx/xx/xx, then the MMI status could be rescinded. She awarded the claimant 4% impairment rating based on range of motion loss.

1-6-12 MD., performed a Designated Doctor Evaluation. He certified the claimant had reached MMI on 11-1-11 which is the last date she saw Dr. and awarded the claimant 0% impairment rating. On extent of injury, it was his opinion that the claimant sustained

a bone contusion and left ankle sprain only. The results of the MRI were preexisting and are not related to the accident.

1-30-12 DC., PhD., performed a Peer Review. He noted that considering the diagnosis of sprain/strain of left ankle, under the ODG Treatment Guideline, 8-10 physical therapy treatment would be indicated, beyond that would be unreasonable and necessary. According to the record, she already has reached MMI as of 11-1-2011 with 0% IR. Based on all the medical records, she has reached MMI as of 11-1-2011. Under the ODG treatment Guideline, based on her diagnosis of sprain/strain, 8-10 physical therapy treatments were indicated from the date of the her injury. No further treatment is indicated. Her prognosis is fair.

4-10-12, MD., noted the claimant returns with persistent discomfort and pain secondary to posterior tibial tendon insufficiency. However, the claimant has persistent good inversion strength with tenderness at the insertion of the posterior tibial tendon. He felt the claimant had nontraumatic rupture of the other tendons of the foot and ankle. He recommended placing her in a short leg cast.

4-10-12 MA, LPC., Initial interview notes the claimant reported during the interview that the primary location of her pain is in her right foot and ankle. The patient reports that her pain seems to move down from her ankle to her foot. The patient used the following words to describe the pain which she experiences since the injury: constant, sharp, throbbing, aching and pins and needles. She rated her pain level at an "8" (based on the VAS scale from 0-10) on an average day. The patient reports that her pain at times can flare up to a level "9" (based on the VAS scale from 0-10) on her worst days, and get down to a level "4" on her best days. Activities that she said increased pain included: walking, standing and other very basic or repetitive activities with her foot. The only things, which the patient reports decrease his levels of pain are rest, elevating the foot/ankle, medication-and physical therapy. She reported sleeping about eight hours at night; however, very interrupted due to the pain and racing thoughts that she experiences. The patient reports that she is "very weak and cannot perform basic activities." The patient reports that her levels of strength, mobility, and endurance are lower than they have ever been. She said that she is no longer interested in the things she once was outside the house. The patient reports that she has always been a very active person throughout her life; however, she now finds herself avoiding any forms of activity that are not necessary -for treatment, due to her fear of re-injury. Current Mental/Emotional: The claimant reports having difficulty managing her pain and experiences a great deal of interference with activities of daily living due to her pain and difficulties adjusting to her injury. She reports feelings of depression and anxiety, which are secondary to the work related injury. The patient reports that she experiences symptoms of appetite increase, energy decrease, inability to get pleasure out of life, boredom, short temper, not able to relax, difficulties adjusting to the injury, restlessness, concentration difficulties, increased concerns about physical health, increased pain with emotionally upset. She is also experiencing stress regarding the treatment process of her injury and would prefer to return to work without experiencing her pain and other physical symptoms. She is under emotional distress and has many feelings that she has

not expressed or explored. She is feeling more sensitive and becoming emotional since her injury. Mrs. has tried to remain as active and involved with her family as possible, however, is having difficulty coping with her pain and adjustment difficulties relating to her injury. She reported that her experience of physical and emotional pain has created problems within her social functioning. Without intervention, these maladaptive behaviors and feelings will continue. She said that her biggest worry was "getting well and returning to work". The Beck Depression Inventory II (BDI-II) is a self-reported inventory that measures the severity of depression in adults. The claimant scored a 39, within the severe range of the assessment. The Beck Anxiety Inventory (BAI) is a self-reported inventory that measures the severity of anxiety in adults. The claimant scored a 20, within the moderate range of the assessment. The Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R) is a tool to aid in treatment decisions for chronic pain patients currently on or being considered for long-term opioid therapy. Clinically, a score of 18 or higher will identify 81% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 18 is .87, which means that most people who have a negative SOAPP-R are likely at low-risk. Finally, the positive likelihood ratio suggests that a positive SOAPP-R score (at a cutoff of 18) is nearly 4 times (3.80 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). The claimant was administered this assessment and scored a 6, indicating a low risk for abuse of prescribed narcotic pain medications. The Fear Avoidance Beliefs Questionnaire (FABQ) was administered to Mrs. Guadalupe Sanchez and the following scores were received:

Work Scale — 36 out of 42 Activity Scale = 20 out of 24

Impressions: The interviewer feels that there is a strong indication that the patient is experiencing pain that is creating interference in her life. It appears as though she is having long-term adjustment problems of depression and anxiety which are secondary to her work-related injury. The following diagnosis is based on the information reported by the patient and this clinician's observation during the face-to-face interview:

DSMIV:

Axis I 309.28 Adjustment Disorder with Mixed Anxiety and Depressed Mood
307.89 Pain Disorder with Both Psychological Factors and a General Medical Condition

Axis II Deferred

Axis III 845.00

718.97

719.07

Axis IV Chronic Pain, financial struggles, multiple social losses, and Problems with family.

Axis V GAF= 60

Mental Status Exam

The claimant was on time for this appointment. She appeared neat and clean, and seemed her stated age. She is a female of tall height and heavy build. She was cooperative and open during the interview. She seemed oriented in all spheres. This interview was conducted in Spanish and her speech was normal in speed and appropriate in volume. Thought processes were logical and goal-directive and her

answers were thoughtful and reflective. Mood was euthymic and relaxed, and affect was appropriate to content. The patient displayed good eye contact and seemed to have good insight and judgment. Recommendations: It is recommended that the claimant be seen for six (6) sessions of individual psychotherapy to address severe levels of stress and depressive symptoms to help patient increase management of her chronic pain. She has high potential to benefit from therapy and psychological interventions given her employment history and her motivated drive to remain as productive as possible.

4-19-12 UR adverse determination. PhD., noted Case discussed with Dr.. The clinical indication and necessity of this procedure could not be established. The mental health evaluation of 4/10/12 finds impressions of adjustment disorder and pain disorder. However, the utilized psychometric instruments (limited to BAI (Beck anxiety inventory), BDI (Beck depression inventory), FABQ (Fear avoidance questionnaire), SOAPP-R (Screeners to Predict Opioid Misuse Among Chronic Pain Patients)) are inadequate/inappropriate to elucidate the pain problem, explicate psychological dysfunction, or inform differential diagnosis in this case; and there is no substantive behavior analysis to provide relevant clinical/diagnostic information [ACOEM. (2008). Chronic pain. Occupational Medicine Practice Guidelines, 2nd ed.; p. 319-320]. It incorrectly identifies the problem as the "right" ankle. The employed psychological tests (other than the SOAPP-R) do not have established peer reviewed, post-market reliability, empirical validity (concurrent or predictive) and normative data to render appropriate sensitivity and specificity for assessment and diagnosis of patients with chronic benign pain/this type of presentation. Therefore, this renders the interpretations questionable; they do not serve as a basis for informing differential diagnosis; and an inflated estimate of reported distress and dysfunction may be inferred. Moreover, the patient has a 3rd grade education, from Mexico; and the reading/comprehension level was not assessed. It is not clear that the patient has an adequate language/reading comprehension level to provide valid responses to these instruments, which tends to inflate reported distress and disability and renders the interpretations questionable [Maruish, E. (2000). Handbook of psychological assessment in primary care settings. New York: Taylor p. 398]. 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. (2011). Pain]. Per all the above, the patient is not an "appropriately identified patient" for whom psychotherapy is both reasonable and necessary at this time [Official Disability Guidelines. (2011). Pain]. Non-approval is recommended.

4-23-12 Request for reconsideration from DC., who noted that psychotherapy was recommended by ODG. The evaluator requested the opportunity to have a peer to peer discussion if there were any questions.

4-30-12 UR Adverse determination. PhD., noted the claimant's presentation is consistent with a Chronic Pain Disorder and the evaluation diagnoses a Chronic Pain Syndrome. ACOEM guidelines state: "There is no quality evidence to support the

independent/unimodal provision of CBT 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]". Cognitive therapy for depression or anxiety is only appropriate when it is the primary focus of treatment, which is not the case with this patient who is reporting chronic pain. 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. DOG (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 session. A recent request for additional PT sessions was denied. The patient is currently working with restrictions. A Peer Review of Records noted that the patient was placed a MMI on 11/1/11 with a 0% impairment rating. The Peer Review concluded "no further treatment is indicated". These issues indicate that 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. He contacted Dr. who stated he was authorized to discuss this case at 10:55am CDT on 4-26-12. Treatment goal, the patient's treatment history, the chronicity of the injury and the patient's current psychological symptoms were discussed. No change in determination. He upheld the adverse determination

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

THE PATIENT HAS AN INJURY DATE OF XX/XX/XX. SHE REPORTEDLY HAD A STRAIN/SPRAIN. SHE HAS HAD DIAGNOSTICS, PHYSICAL THERAPY, AND MEDICATIONS. SHE RATED HER PAIN AS 8/10 AND HAS A BDI OF 39 AND BAI OF 20. SHE WAS NOTED TO HAVE BEEN PLACED AT MMI ON 8/30/11 AND 11/01/11. RECORDS INDICATE THAT THE PATIENT'S INJURY SHOULD HAVE HEALED LONG AGO AND THAT SHE SHOULD BE ABLE TO RETURN TO WORK. THE TESTING INCLUDED DOES NOT SUFFICIENTLY EXPLAIN THIS. THERE IS NO CLEAR DOCUMENTATION AS TO HOW HER DOCTOR HAS ADDRESSED HER REPORTED SYMPTOMS OF DISTRESS. BASED ON THE AVAILABLE INFORMATION, THE REQUEST FOR INDIVIDUAL PSYCHOTHERAPY 1 X 6 WEEKS (6 SESSIONS) CANNOT BE ESTABLISHED AS REASONABLE AND MEDICALLY NECESSARY, PER EVIDENCE-BASED GUIDELINES.

ODG-TWC, last update 2-20-12 occupational disorders - low back chapter:

Behavioral treatment: Recommended as option for patients with chronic low back pain and delayed recovery. Also recommended as a component of a Chronic pain program (see the Pain Chapter). Behavioral treatment, specifically cognitive behavioral therapy (CBT), may be an effective treatment for patients with chronic low back pain, but it is still unknown what type of patients benefit most from what type of behavioral treatment. Some studies provide evidence that intensive multidisciplinary bio-psycho-social

rehabilitation with a functional restoration approach improves pain and function. (Newton-John, 1995) (Hasenbring, 1999) (van Tulder-Cochrane, 2001) (Ostelo-Cochrane, 2005) (Airaksinen, 2006) (Linton, 2006) (Kaapa, 2006) (Jellema, 2006) Recent clinical trials concluded that patients with chronic low back pain who followed cognitive intervention and exercise programs improved significantly in muscle strength compared with patients who underwent lumbar fusion or placebo. (Keller, 2004) (Storheim, 2003) (Schonstein, 2003).

ODG-TWC, last update 4-16-12 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-behavioural 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 KNOWLEDGBASE

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)**