

IRO NOTICE OF DECISION – WC



Notice of Independent Review Decision

IRO REVIEWER REPORT - WC

[Date notice sent to all parties]: November 1, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPT 99361, 97002, 90801 DOS 7/19/12 and CPT 99212 DOS 8/23/12

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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- 9-27-11 office visit.

- 2-24-12 performed a Peer Review.
- 3-2-12 Notice of Disputed Issues.
- 3-5-12 office visit.
- 7-19-12 Physical Performance Evaluation Assessment.
- 7-19-12 - office visit.
- 7-19-12 Psychological diagnostic evaluation and psychological testing.
- 8-23-12 office visit.

PATIENT CLINICAL HISTORY [SUMMARY]:

9-27-11, the claimant feels the pattern of symptoms is worsening. Patient has been working within the duty restrictions. Patient has been taking his medications as needed. Patient has had physical therapy with some improvement noted. The pain is located on left abdominal wall and now has complaints of more and more lumbar pain and occasional numbness into right foot and toes. Would like to return to full duty but on discussion, this does not seem feasible to him. On exam, Lumbar: Tender spasm bilateral low lumbar. Positive leg raising on right. Reflexes symmetric. No spinous process tenderness. No point tenderness. Normal sensation. Decreased active range of motion: All directions: With pain. And due to splinting. Abdomen: Tender lateral left abdominal wall costal margin to ilium. Tender with side bending and rotation. Assessment: Lumbar radiculopathy, lumbar strain, abdominal wall strain. Plan: work with restrictions, physical therapy, referral for MRI, and continue with Ibuprofen 200 mg.

2-24-12 performed a Peer Review. There is insufficient objective medical evidence that the late-developing lumbar and leg symptoms are related to the DOI, or that the symptoms are related objectively to any or all of the lumbar MRI findings. The MOI would not be anticipated to produce injury to the lumbar axial skeleton. If there had been an acute injury to the lumbar axial skeleton, particularly one that would rupture a disc and acutely compress a nerve root, it would be anticipated to produce symptoms acutely at the time of the alleged injury, not one month later. The claimant has objective x-ray evidence of multilevel degenerative spondylosis, not acute trauma, which is a pre-existing condition that does not appear to have been caused by, temporarily exacerbated by, or permanently aggravated by the MOI based on the documentation herewith. There is insufficient objective clinical and imaging evidence of acute injury to the lumbar axial skeleton. There is insufficient clinical evidence of radiculopathy, per ODG criteria. There is insufficient objective evidence of "discogenic" pain. There is insufficient evidence of spinal segmental instability.

3-2-12 Notice of Disputed Issues. The carrier disputed the MRI findings on 10-14-11.

3-5-12 the claimant was seen for recheck of lumbar, left hip and left lower abdominal pain that began that has been present since his injury when he was pinned between 2 large trucks at work on September 1, 2011. Since his last visit, his symptoms are unchanged. He notes that the abdominal pain is not as intense as it was previously but is made uncomfortable when he is arising from a supine to a seated or standing position. He continues to have sharp shooting back pain that radiates from the low back into the left buttock and that interferes with sleep. He continues to have tingling that extends from the low back into the left buttock and into the leg to then to the knee, along with numbness that seems to be getting worse. He is also having problems walking as he feels more weak in his left leg compared to his right. He was suppose to undergo a procedure tomorrow but had to reschedule. He has been taking Mobic, Flexeril and Ultram with some mild relief of his pain. He has not been working as he is unable to tolerate light duty. He has been to PT prior but not in the last few weeks. He denies any bowel or bladder incontinence, fevers, or chills. Underwent a CT scan of the lower extremity back on January 30, 2012, which did not reveal a fracture or dislocation, but does have a posterior disc herniation at L5-S1 with left foraminal prominence since he has complained and still has a painful lump around the left PSIS of the hip. Plan: Renew Ultram and Neurontin. Hold Flexeril and Mobic for now. Referral for further treatment and EMG/NCS of the left lower extremity as he has sensory and motor deficits on exam. No activity status.

7-19-12 Physical Performance Evaluation assessment: The claimant presents to DSRC for physical performance evaluation secondary to injury that occurred on 9/1/11. Pt complains of lumbar pain. Left LE pain/tingling to foot. Pt's current pain level is 10. Pt has had a complicated course of recovery. He states he was "on the way to surgery" at one point when he received word the procedure was denied. He has had two MRIs. One revealed an 8mm disc, the other a "4.5 mm disc" per patient report. He did participate in OP PT but "was not able to handle it". He again relates frustration when discussing this condition. He is now 10 months post injury and lower levels of care have not fully aided this patient in a return to function. Recommended injection was denied. Pre injury function has not been restored with this patient. He continues to take pain medication for this injury. Lower levels of care have been markedly unsuccessful. Recommend functional restoration to avoid a controversial surgery.

7-19-12 - Patient had initial TPE in April 2012. At that time the treatment team recommended lumbar ESI due to the fact that the claimant had undergone previous ESI related to this injury and experienced benefit. The team anticipated that following the ESI he would be a good candidate for the Functional Restoration Program. Current Status: The medical options that have been recommended for the claimant have been denied, including ESI. He has had lesser levels of care and reached a plateau. His TIBS have recently stopped. He has a 4 year work history with NTB as an auto technician/service manager. At this point he cannot meet the physical demands of the job. Plan: The treatment team is recommending the Functional Restoration program with the goal of acquiring pain management skills, as well as, becoming as functional as possible in order to

return to the work force. will seek authorization for the program. Please note that the above case management activity has been done in coordination with the treating doctor, as the DWC emphasized in the adoption of Chapter 137 Disability Management Rules. As noted in the new Medical fee guidelines, "the Division has recognized the contribution of referral health care providers contributing to the activity recognizing that communication between referral providers and the treating doctor for claims requiring medical case management is a normal business practice, and appropriate communication results in efficient care of the injured employee as well as an efficient medical practice.

7-19-12 Psychological diagnostic evaluation and psychological testing report notes the claimant reports that he is getting depressed and just frustrated. The claimant does not report any current treatment for anxiety, depression, or mental health problems. The claimant does not report a history of mental health problems or treatment prior to the injury.

Diagnoses:

Axis I 307.89 pain disorder associated with psychological factors and general medical condition

Axis II V79.01 no diagnosis on axis II
Obsessive-compulsive personality traits

Axis III Chronic pain from injury

Axis IV Chronic pain, significant disruption of activities of daily living, inability to work, significant financial stress

Axis V GAF = 59 (current).

Summary and Recommendations: The claimant is a 34-year-old male referred for treatment in a functional restoration program. He referred to the medical and physical therapy evaluation for details. and the team do concur that the claimant is very appropriate for a functional restoration program under the Official Disability Guidelines. The claimant continues to have debilitating chronic pain. There are no more medical options available to him under workers comp for this injury. does not see any options under workers comp at this time to help him obtain a higher level of function and manage his pain more effectively and hopefully return back to some type of employment. He has lost his income and is desperately wanting to get something moving forward to help to either be able to work or get his life better. The claimant certainly meets criteria under the Official Disability Guidelines for admission to this structured program.

All negative predictors of success have been evaluated and considered or addressed. The claimant does have some depression and anxiety that it is directly related to his injury and the resulting pain and disruption of his life and he struggles with getting medical treatment. It is connected/related to the injury. It is something that in spite of everything he is managing relatively well. It is something that can be very appropriately addressed and adequately addressed within the confines of an interdisciplinary functional restoration program. The individual therapy, group therapy, pain management training, cognitive behavioral therapy in conjunction with the physical therapy and function training will be very appropriate and helpful. The team does concur with the Official Disability Guidelines that unimodal treatment would not be appropriate nor effective.

8-23-12, the claimant is still in limbo. He has not advanced to be entered into the functional restoration program. They have received a request from the Sun Life Assurance Company of Canada for his long term disability claim. They are in need of an FCE to clearly delineate and answer the questions presented by the insurance company. In the case this is refused they will do our best to evaluate his status and give a response to the insurance company and long term disability claim. Disposition: His pain is doing quite well. He gave him Tramadol 50 mg three tablets. He takes a tablet only on a pm basis when the pain becomes intolerable. The patient has been given two refills. This examinee is to return for follow-up after he has had his FCE carried.

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

99361 - Medical Conference
97002 Physical therapy reevaluation
90801 Psychological Diagnostic Interview Examination
99212 Office or other outpatient visit

The available information has been reviewed. The claimant has an injury date of xx/xx/xx. He has had diagnostics, physical therapy, consults, and medications. He was reportedly working light duty as of 9/27/11 but is not currently working. A Psychological Evaluation dated 7/19/12 notes that he does not report significant symptoms of depression, anxiety, or other significant psychological symptoms. It is noted that and the team do concur on his treatment plan. A note dated 7/19/12 recommends he have an ESI. Per a note dated 8/23/12 states that he does not believe the patient is ready to advance to be in a functional restoration program. A note dated 8/23/12 states that the patient is applying for long term disability, his pain is "quite well," and he prescribed Tramadol. A PPT notes that the patient reported a pain level of 10/10 and recommended he participate in a functional pain program to "avoid surgery." A Peer Review dated 2/24/12 notes that he has pre-existing conditions and none of his other reported diagnoses are related to his injury and a chronic pain management program was not necessary. The Psychological Evaluation dated 7/19/12 notes that the patient has a BDI of 210, BAI of 23, and fear-avoidance issues. The MCMI-II reported noted that he did not have significant symptoms of depression, anxiety, or other psychological symptoms of distress. There is clearly a documented lack of coordinated treatment plan with at least two notes reporting that the patient did not endorse significant symptoms of psychological distress. Therefore, given the available information, the request for 99361 and 99212 appear to be reasonable and necessary per evidence-based guidelines. However, based on the records provided, the requests for a 90801 and 97002 do not appear to be reasonable and necessary per evidence-based guidelines.

99212 Doctor's visit for the evaluation of an established patient for a problem-focused examination and a simple medical decision

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Per ODG 2012 psychological evaluations: 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.

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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)