ReviewTex. Inc.
1818 Mountjoy Drive
San Antonio, TX 78232
(phone) 210-598-9381 (fax) 210-598-9382
reviewtex@hotmail.com

Notice of Independent Review Decision

Date: 9/2/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Psych Interview
PSYCL TSTG PR HR F2F TIME W/PT

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

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

X Upheld (Agree)

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:
Cover sheet and working documents
Utilization review determination dated 07/12/12, 07/23/12
Office visit note dated 01/17/12
Referral form dated 07/03/12
OV consultation dated 01/23/12-06/18/12
Behavioral health preauthorization request dated 07/09/12
Reconsideration dated 07/12/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female whose date of injury is xx/xx/xx. On this date the patient's right hand started hurting. Preauthorization request dated 07/09/12 indicates that the current request is for establishing a mental health impairment rating. Initial

request was non-certified on 07/12/12 noting that there is no notation of mechanism of injury, diagnostic work up or results of apparently 2 orthopedic consults. There is also no notation of any emotional, psychological or social symptoms. There is no notation of medication use. There is no notation of return to work although there is mention of DWC 73 without specifics. There is notation of referral for impairment rating 04/24/12, but no mention as to results and what was included in rating. There is lack of clinical information regarding mental health history or past or current psychological symptoms. There is mention of pain and pain management modalities but here is no mention of depression, anxiety, sleep disturbance, change in appetite/weight, change in social interaction or current functional level that would necessitate further in-depth psychological evaluation or testing. Reconsideration dated 07/12/12 indicates that the current request is for establishing a mental health impairment rating. The denial was upheld on appeal dated 07/23/12 noting that this is an extremely unusual request and not within ODG guidelines. The reconsideration letter noted that the previous reviewer was outside the area of expertise, but did not address the substantive issues of lack of information in the records about psychological issues, and the need to establish a psychological component of the injury. Per telephonic consultation with the requesting provider, he believes that the patient underwent a previous psychological evaluation. If there has been a previous diagnostic interview the current request is unnecessary, since the previous diagnostic interview would give any evidence of psychological problems that could be taken into account in issuing an impairment rating.

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 psyche interview, psycl tstg pr hr F2F time w/PT is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no psychological evaluation or testing provided to establish a working diagnosis or document any psychological symptomatology. There is no documentation regarding psychological treatment completed to date or the patient’s response thereto provided. Given the gross lack of supporting documentation and noting that the request is outside ODG guidelines, the request is not indicated as medically necessary.

IRO REVIEWER REPORT TEMPLATE –WC

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

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

X 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. Note: Psychometrics are very important in the evaluation of chronic complex pain problems, but there are some caveats. Not every patient with chronic pain needs to have a psychometric exam. Only those with complex or confounding issues. Evaluation by a psychologist is often very useful and sometimes detrimental, depending on the psychologist and the patient. Careful selection is needed. Psychometrics can be part of the physical examination, but in many instances this requires more time than may be allocated to the examination. Also it should not be bundled into the payment but rather should be reimbursed separately. There are many psychometric tests with many different purposes. There is no single test that can measure all the variables. Hence a battery from which ther appropriate test can be selected is useful.
Psychological evaluations,	Recommended pre intrathecal drug delivery systems (IDDS) and spinal cord stimulator (SCS) trial. The existing

IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators)	behavioral literature provides considerable support, including psychological assessments and treatments, for patients undergoing spinal cord stimulators or implanted medication pumps. (Van Dorsten, 2006) The following is a list of patients who are especially recommended for psychological evaluation pre- trial (Doleys): (a) Those who present with constant pain and report high overall levels of distress; (b) Patients' who have a history of failure of conservative therapy; (c) Patient's who have a history of failed surgery; (d) Patients who have significant psychological risk factors such as substance abuse, serious mood disorders, or serious personality disorders. Psychological predictors of success and/or failure of implantable treatment are still under research, and there is at least one study that has found psychological testing to be of modest value (although this was based on a cohort of patients that had been pre-screened by their surgeon). (North, 1996) However, the screening should be performed by a neutral independent psychologist or psychiatrist unaffiliated with treating physician/ spine surgeon to avoid bias. Current suggestions for the evaluation include the following three pronged approach (Prager, 2001) (Beltrutti, 2004) (Monsalve, 2000): (1) A clinical interview including the following: (a) Social history including education, psychosocial stress factors, childhood history (including history of abuse), family situation and work history; (b) Comprehensive history including previous treatment (and response), psychological history; (c) History of substance abuse; (c) Attitudes towards pain and treatment, including painful behavior and moods of the patient; (e) Current emotional state; (f) Mental status exam; (g) Determination of motivation for recovery and return to work; (h) Issues related to implantation therapy. The interview should allow for measures of personality structure (both before and after the illness), environmental factors that influence pain, and personal strengths and internal resources. (2) An interview with a significant other (if approved by the patient) to confirm findings, alert for other significant information, and allow for assessment of social support. (3) 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 Speilberger 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.