

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: February 1, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

95101 Mental Health Testing x2 Hours, 90801 Repeat Diagnostic Interview x1 Hour

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

The Reviewer is a Licensed Psychologist with over 25 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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

04/19/10: Follow-up Evaluation
08/11/10: Follow-up Evaluation
12/02/10: Patient Notes
12/06/10: Follow-up Evaluation
01/06/11: UR performed. Requested service: EMG/NCV bilateral lower extremities.
01/10/11: Peer Review/UR
01/18/11: Peer Review/UR
01/25/11: Peer Outreach Summary
01/31/11: Electrodiagnostic Consultation
02/08/11: Medication Review
02/10/11: Patient Notes
04/11/11: Follow-up Evaluation
05/20/11: Follow-up Evaluation

06/23/11: Patient Notes
09/12/11: Follow-up Evaluation
10/13/11: Patient Notes
01/26/12: Patient Notes
05/24/12: Patient Notes
07/10/12: Peer Review/UR
10/04/12: Patient Notes
11/07/12: UR performed
11/19/12: Response to Denial Letter

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx from a lifting type injury. He was initially treated for a lumbar strain with medication, physical therapy and ESI. A MRI of the lumbar region performed in December of 1998 showed degenerative changes in the lumbar spine at L4-S1 with central disc herniation. An EMG/NCS performed in August of 1999 revealed right L5-S1 radiculopathy. Continued conservative treatment failed, so on January 4, 2000, performed a laminectomy, discectomy, and fusion. He continued to be symptomatic and was diagnosed with failed lumbar laminectomy and fusion. On September 12, 2001, removed the instrumentation and performed a re-fusion, hemilaminectomy and neurolysis. This also failed to produce any significant resolution to either pain symptoms or function. He went under the supervision and his treatment consisted of medications, a chronic pain management program in 2002, and a permanent spinal cord stimulator was implanted on February 5, 2003. The claimant underwent a urology evaluation in January of 2005 as he continued to have post injury erectile dysfunction for which he was prescribed Viagra. The erectile dysfunction was accepted as a compensable diagnosis upon litigation.

On April 19, 2010, the claimant had a follow up evaluation who reported the continued to complain of low back pain, rated 6-7/10, with a burning sensation in the sole of each foot, right more than the left. He also had pain coming down the right posterior thigh and described a very tight constricting type of pain in the right thigh. When his right-sided pain got worse, he noticed that he would also get left testicular pain, but never right testicular pain. He was on the following medications: Gabapentin 600 mg, Skelaxin 800 mg, Plaquenil 500 mg, and Lorazepam 30 mg.

On December 2, 2010, the claimant had a follow up evaluation who reported he was taking Viagra for erectile dysfunction and that it was working very well.

On December 6, 2010, the claimant had a follow up evaluation with who reported a sensation as though he had ants crawling on his penis. Those particular symptoms had been present for about 2 weeks. The claimant stated he had talked to his Urologist, about the new symptoms.

On January 31, 2011, the claimant underwent an EMG/NCV which revealed evidence of chronic, ongoing right L5 radiculopathy.

On February 10, 2011, the claimant had a follow up evaluation with who continued him on Viagra.

On January 26, 2012, the claimant had a follow up evaluation who reported he had not had sex for over 3 months. He still had Viagra, but had no desire to use it. She recommended checking his testosterone levels and that he could also have depression, so referred him for a psych eval.

On July 10, 2012, performed a Peer Review/UR in which the following opinions were rendered: In response to Question No. 1: "At this point, the only treatment noted would be Viagra (by CCH decisions, Neurontin and Skelaxin. A back brace is also mentioned. Of the three remaining treatments (Neurontin, Skelaxin, and Back brace), none of these are really supported at this point by ODG. The medicines can be weaned over the course of one month and discontinued. The back brace can be stopped without weaning." In response to Question No. 4: "Yes, the erectile dysfunction at this point in his life is far more likely a condition of age, and with passing time, is less and less likely due to the original injury, especially given the radiculopathy was effectively treated, with no evidence of electrodiagnostic studies." In response to Question No. 5: "No. For reasons shared earlier, although the Viagra is reasonable, and probably needed, it is for erectile dysfunction due to natural aging and its need can no longer be related to the original injury from 14 years ago."

On November 7, 2012, performed a UR. Rationale for Denial: The patient is noted to be taking Skelaxin and ibuprofen. The referral notes the request is to assist in treatment planning. With an injury date of 1998, there is little information provided. reported that she has little information about the patient's background and they have not seen the patient before. She reported that the referral was made by originally in January but they were unable to schedule the patient. She reported that the referral has been made again and they are wanting to see if his erectile issues and other issues are injury related, related to psychological factors, or related to his medications. This patient has had these issues addressed per the review of records from a reported dated 07/10/12 by and the patient has had psychological treatment in addition to multiple other treatments over the years with many treatments specifically to address the issues of concern raised currently. Based on the limited information submitted and the treatment the patient has had to date, the request for a clinical interview and psychological testing cannot be established as reasonable and necessary, per evidence-based guidelines.

On November 19, 2012, wrote a Response to Denial Letter in which she stated that on November 4, 2012, requested 1 hour for Diagnostic interview. She went on to state that the current request of individual psychotherapy is to address physical/somatic symptoms or psycho physiological symptoms related to the patient's erectile dysfunction. The recommendations were based on the psychological/emotional aspects of the injury, the treatment history, response to treatment and psychosocial stressors that may be hindering expected recovery as a means to reduce any psychosocial stressors that may very well hinder the

patient from adequate recovery from his work injury. The 1 hour request for a Diagnostic interview is required prior to requesting individual psychotherapy. According to ODG, an 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).

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

The previous adverse determinations are upheld: 1) The UR performed on July 10, 2012 correctly concludes that the erectile dysfunction at this point in his life is far more likely a condition of age especially given the radiculopathy was effectively treated. And although Viagra is reasonable and probably needed for erectile dysfunction due to natural aging, its need can no longer be related to the original injury from 14 years ago. It was also reported in the records that his erectile dysfunction was affectively treated with Viagra; 2) The UR on November 7, 2012 correctly concludes that based on the limited information submitted and the treatment the claimant has had to date, the request for a clinical interview and psychological testing cannot be established as reasonable and necessary, per evidence-based guidelines. Therefore, the request for 95101 Mental Health Testing x2 Hours, 90801 Repeat Diagnostic Interview x1 Hour is not found to be medically necessary at this time.

PER ODG:

<p>Psychological evaluations</p>	<p>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</p>
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	<p>Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superseded 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. See also the Stress/Mental Chapter.</p>
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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)**