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Notice of Independent Review Decision

DATE: December 10, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar Individual Psychotherapy Six Sessions
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:
03/22/06: Independent Medical Examination
07/01/07: Medical Review
02/08/11: Progress Note
02/08/11: MMI and Impairment Rating
05/12/12: Followup Visit
05/29/12: Followup Visit
05/29/12: New Patient Visit
05/31/12: Letter
06/04/12: Mental health Evaluation/Treatment
06/26/12: Followup visit
07/12/12: Disability Determination Services Diagnostic Psychiatric Evaluation
07/31/12: Followup Visit
09/01/12: Initial Diagnostic Screening
09/11/12: Followup Visit
11/02/12, 11/05/12: Notes
11/05/12: UR performed

11/09/12: Response to Denial Letter
11/14/12: Pre-Authorization Appeal
11/21/12: UR performed
11/27/12: Prospective Review

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who injured his low back while working on a machine when it tipped forwards and backwards.

03/22/06: Independent Medical Examination. RECOMMENDATIONS: The diagnosis remains acute lumbar strain (resolved) with protruding intervertebral disc without verifiable radiculopathy in the setting or pre-existing and unrelated degenerative lumbar spine disease. The claimant presents with a perception of his symptoms and limitations that is not consistent with objective findings and may represent symptom magnification. The only current treatment is limited to medications, which may be directed at unverifiable subjective symptoms, but are not necessary for healing. Under these circumstances, there is no objective indication for additional treatment for the medical condition related to the work injury of September 03, 2002.

07/01/07: Medical Review. Are current signs and symptoms related to this compensable injury? No. It is far and away excessive to consider this patient's riding a bobcat has produced lifelong changes in his lumbar spine now considered to be a herniated L4-L5 disc and is now producing symptoms. The time frame is in error. There is good evidence-based medical literature published now with cohort studies that suggest these kinds of events in a life produce nothing more than an ordinary disease of life. These are not traumatic and are thought to be more hereditary/congenital in nature. I would offer Dr. article published in Spine below. What ongoing treatment is necessary as it relates to the work event? I would strongly recommend Dr. evaluation serve as closure as to the necessity of future medical treatment for his work related injury.

02/08/11: MMI and Impairment Rating. ASSESSMENT: Shoulder pain. Contracture of joint of shoulder region. PLAN: I calculated this patient's Impairment using the AMA Guides to the Evaluation of Permanent Impairment, four edition. He will have impairment based upon his shoulder contracture and distal clavicle resection history. His whole person permanent impairment is 14%. Date of Maximum Medical Improvement: 02/08/11.

05/12/12: The claimant was evaluated for injuries to his lumbar spine. He noted that his pain on a VA scale of 0-10 was between 3 ½ at best and a 7 at worst. He noted that he had some increasing radicular complaints into the lower extremity, which had increased over the last 1-2 years. He had difficulty with his sleep pattern, which had increased over the last 1-2 years. He had difficulty with his daily living activities. On examination, he showed palpatory findings of chronic myofascial irritation of the lumbar paraspinals. Strength evaluation for the trunk was 4+/5, reduced secondary to pain. He had altered body mechanics at extreme

range of motion. Orthopedically, he demonstrated a positive disc compression with Nachlas and bilateral sciatic notch test. Range of motion of the lumbar spine showed restriction, particularly with extension secondary to pain. Lower extremity strength was 5-/5. Reflexes in the lower extremity were +2/+4 for the bilateral knees and ankles. Sensory evaluation showed minimal hypoesthesia bilaterally at L5-S1. Past medical history was positive for a history of anxiety. His current medications included Nexium, hydrocodone, Effexor, and Neurontin. IMPRESSION: Lumbar HNP, lumbar nerve root irritation, lumbar radiculopathy, lumbar facet arthropathy. PLAN: Followup in 30 days. Refer to Dr. for medication management. Refer to Dr. for determination regarding interventional pain management. Request all prior records for complete review. Maintain no work status at this time period.

05/29/12: The claimant was reevaluated by DC. He noted his pain to range from 4-7/10. He continued to have radicular complaints from the lumbar spine into his lower extremity. It was noted that his daily living activities increased his pain and discomfort. Examination showed that he had no significant changes since 05/12/12. PLAN: Followup in 60 days. Maintain no work status for 60 days. Refer to Dr. for determination regarding interventional pain management. Refer to Dr. for medication management.

05/29/12: The claimant was evaluated by MD for a lumbar sprain. It was noted that he quit his custodian job in February of 2012 to care for his wife who has M.S. His pain was noted to be primarily in the middle of his lumbar area with some left radicular pain down into the left knee. He had considerable lumbar muscle spasms. He was given prescriptions for Flexeril, Neurontin, Norco, and ibuprofen.

06/26/12: The claimant was reevaluated by MD. It was noted that his medications were providing a lot of relief of his pain and muscle spasms. It was noted that he needed no new prescriptions at that time. PLAN: Continue present medications. Return in one month.

07/12/12: The claimant was evaluated by MD. It was noted that he “quit his job to care for his wife who is disabled with multiple sclerosis. He was also suffering knee and back pain secondary to the stress physical demands of his work. Additionally, he states he has been depressed for 10 years.” It was noted that Citalopram helped with his depressive symptoms but he did still feel somewhat depressed most of the time. It was noted that he was sleeping about nine hours at night but did not sleep during the day and that he had poor energy. It was noted that his concentration was somewhat decreased. He was not suicidal, homicidal, and did not have auditory or visual hallucinations. He was noted to become suddenly anxious when he had negative thoughts. It was noted that he did lose his temper occasionally and he could even become physical on rare occasions. He usually became aggravated towards his family and, more rarely, towards strangers. He was appropriate with authority figures. It was noted that he spent his days taking care of his wife mainly but also cared for his father three times per week and that he did the housework and prepared the meals.

DIAGNOSES: Major depressive disorder without psychotic features. Anxiety disorder, NOS. Chronic musculoskeletal pain. Psychosocial stressors – unemployment. Current GAF – 60; highest GAF in the past year – 60. PROGNOSIS: The prognosis is fair for this gentleman. CAPABILITY STATEMENT: I have completed TRC Form-886.

07/31/12: The claimant was reevaluated by MD. It was noted that his "carrier had denied his medications. Peer Review – Recommend no further medical treatment." It was noted that he claimed to have low back pain and radicular pain down the left leg. He was given a sample of Meloxicam.

09/01/12: Initial Diagnostic Screening. CLINICAL IMPRESSIONS: Felix reported affective anxiety, depression, sleep disturbances, and vocational concerns started approximately 4-5 months after his work injury on 09/03/02. On the FABQ, his Physical Sub Scale score was 22 and his Work Sub Scale score was 25. On the Patient Pain Drawing, he rated his pain ranging between 3 and 4 on a scale from 0-10. On the Pain Experience Scale, he scored an 87 indicating a significant level of pain. He scored a 30 on the McGill Pain Questionnaire. On the Revised Oswestry Low Back Pain Disability Questionnaire, he reported a 36% moderate perception of disability. According to the Beck Depression Inventory, he scored 28, indication of a moderate level of depression. He scored 21 on the Beck Anxiety Inventory indicating a moderate level of anxiety. On the Sleep Questionnaire, he scored 33, indicating a moderate to serious level of sleep problems. DIAGNOSTIC IMPRESSION: Mood disorder due to a medical condition with depressive features. Psychosocial stressors related to injury – physical health, occupational/work, economic/financial, primary support group/family/marital. Psychosocial stressors related to injury (severity): 4, Severe. Global assessment of functioning (current): 50, serious with new work injury stressors. Global Assessment of Functioning (prior to injury): 70, average in most areas. TREATMENT PLAN/RECOMMENDATIONS: Individual Psychotherapy, Cognitive Behavioral, 6 units, 1 x per week, 6 weeks.

09/11/12: The claimant was reevaluated by DC. He noted his pain to be from 2 ½ to 7 out of 10. He had ongoing radicular complaints from the lumbar spine into the lower extremity. It was noted that medication management in the past had been very helpful for him as well as continuation of his independent home exercise program. On examination, he had a positive disc compression, Nachlas, bilateral sciatic notch test. Strength was 5-/5, reduced secondary to pain. He had evidence of chronic myofascial irritation of the bilateral lumbar paraspinals. Range of motion of the lumbar spine was reduced moderately in all ranges with pain at extreme. He had loss of proper body mechanics as noted previously with extension. DTRs were +2/+4 in the lower extremities. Sensory exam revealed hypoesthesia bilaterally L5-S1. CLINICAL IMPRESSION: Lumbar HNP, lumbar nerve root irritation, lumbar radiculopathy, facet arthropathy, work-related. PLAN: Followup in 90 days. Maintain no work status for 90 days. Continue medication management per Dr. As noted previously, he has medication denial and this will

be taken to the Texas Department of Insurance for adjudication with the Office of Injured Employee Counsel.

11/05/12: UR performed. RATIONALE: Physician advisor completed a peer-to-peer phone consultation on 11/05/12. They discussed the case clinical records. She stated they only recently began treating him with chiropractic intervention. The documents provided for the requested individual psychotherapy do not provide sufficient information to justify implementing additional treatment for this claimant whose injury occurred about XX years ago; therefore, the requested treatment is not medically necessary or reasonable. Official Disability Guidelines call for clear identification of the manner in which a proposed treatment program is directly related to a reported injury.

11/21/12: UR performed. RATIONALE: Physician advisor completed a peer-to-peer phone consultation. They discussed the case clinical records. Given the inconsistencies in his reports of level of symptoms and disability, as well as discrepancies about why he is now off work, further assessment of motivational influences, secondary gain, and other influences on his symptom reports needs to take place before treatment is started, since such findings may affect the type of necessity of such treatment. Thus, he is not yet shown to be appropriately identified for the requested therapy as indicated in Official Disability Guidelines.

11/27/12: Prospective Review (M2). "According to the Official Disability Guidelines, psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's beliefs and coping styles, assessing psychological and cognitive function and addressing co-morbid mood disorders. As stated by the Physician Advisor, documented information did not provide sufficient evidence to justify implementing additional treatment for this claimant whose injury occurred XX years ago. It was not clear that the proposed treatment program is directly related to a reported injury. Therefore, based on the reviewed documentation, the medical necessity for the currently proposed six sessions of individual psychotherapy at Nueva Vida Behavioral Health Associates as requested by DC is not substantiated for this claimant. At this point, as discussed by the Physician Advisor it is recommended to deeper review the claimant's medical records to check if current depression/anxiety problems are directly related to the injury that occurred over 10 years ago."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. According to the Independent Medical Evaluation, the claimant may present with "symptom magnification." In addition, the Medical Review concluded that his current signs and symptoms are not related to the injury. I would agree to the above as well as the UR performed correctly concluding that "documents provided for the requested individual psychotherapy do not provide sufficient information to justify implementing additional treatment" and "Official Disability Guidelines call for clear identification

of the manner in which a proposed treatment program is directly related to a reported injury." The UR performed correctly concluded that "he has not yet shown to be appropriately identified for the requested therapy as indicated in ODG." There are inconsistencies in his reports of level of symptoms and disability and discrepancies about why he is off work now. He does not meet ODG criteria. Therefore, the request for Lumbar Individual Psychotherapy Six Sessions at Nueva Vida Behavioral Health Associates as Requested is not medically necessary and is non-certified.

ODG:

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) Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate on this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). (Lang, 2003) A recent RCT concluded that lumbar fusion failed to show any benefit over cognitive intervention and exercises, for patients with chronic low back pain after previous surgery for disc herniation. (Brox, 2006) Another trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. (The cognitive treatment focused on encouraging increased physical activity.) (Smeets, 2006) For chronic LBP, cognitive intervention may be equivalent to lumbar fusion without the potentially high surgical complication rates. (Ivar Brox-*Spine*, 2003) (Fairbank-*BMJ*, 2005) Cognitive behavioral therapy (CBT) significantly improves subacute and chronic low back pain both in the short term and during 1 year compared with advice alone and is highly cost-effective, a new RCT suggests. Disability scores as measured by the Roland Morris questionnaire improved by 2.4 points at the end of 12 months in the CBT group compared with 1.1 points among control patients. Patients were treated with up to 6 sessions of group CBT, whereas controls received no additional treatment other than a 15-minute session of active management advice. According to self-rated benefit from treatment, results showed that 59% of patients assigned to CBT reported recovery at 12 months compared with 31% of controls. Fear avoidance, pain self-efficacy, and the Short Form Health Survey physical scores also improved substantially in the CBT group but not in the control group. The CBT taught people how to challenge their fear of making things worse and to test out ways of improving their physical activity. (Lamb, 2010) See also Multi-disciplinary pain programs in the Pain Chapter. See also Psychosocial adjunctive methods in the Mental Illness & Stress Chapter. **ODG cognitive behavioral therapy (CBT) guidelines for low back problems:** 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 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)

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)**