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The Psychiatry Issue

IN THIS ISSUE

- Psychologic Assessment for Chronic Pain Procedures
- Interview with Psychiatrist Greg Kyser, MD
- Injured Workers Need Your Assistance
- MIRR Doctor’s Mental Injury Rating Affirmed on Appeal

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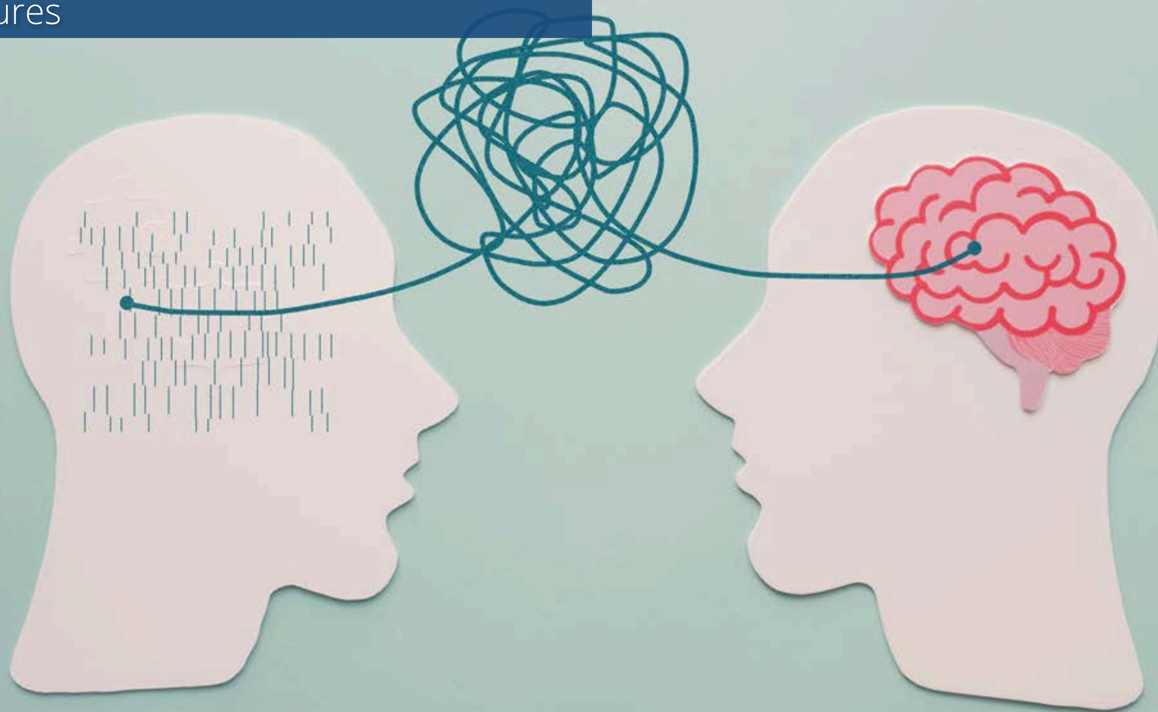

Psychologic Assessment for Chronic Pain Procedures

Psychologic Assessment for Chronic Pain Procedures

James B. Talmage MD and Les Kertay PhD

James B. Talmage MD (left) and Les Kertay PhD (right)

The Tennessee Bureau of Workers' Compensation (TN BWC) adopted the Official Disability Guidelines (ODG – now "ODG by MCG") as presumptively correct for Utilization Review decisions, and UR Vendors almost always cite the ODG criteria in certifying, or non-certifying, requested tests or treatments for TN workers' compensation cases. The exceptions are the uncommon requests for procedures for which there is no ODG section that is applicable. Examples would be a request for a sixth operation for non-union of the same fracture, or a third labrum repair on the same shoulder.

The BWC Office of the Medical Director (OMD) receives appeals of UR denials of procedures for which the indication is chronic pain relief. Examples are spinal fusion for back pain, and spinal cord stimulator trial or permanent implantation for chronic back and leg pain. For these procedures an ODG criterion is a "favorable" psychological assessment, which has proven to be problematic.

The Authorized Treating Physician (ATP) orders a "Psychologic Assessment" with typically no additional information provided to the psychologist or psychiatrist. What the BWC typically sees in these psychologist assessments is an evaluation that states the patient is not psychotic, has depression or anxiety symptoms (and frequently diagnoses) that are being treated, has the legal ability to make decisions about their health care, and understands the unstated "risks and benefits" of the proposed procedure.

What the ATP wants to see is "psych clearance has been obtained, and the patient is 'OK' for the planned procedure for pain".

However, the **reason** psychological assessment is an ODG criterion is that invasive procedures have risks of significant complications, and at times even death, and there is little reason for an UR MD to certify as "medically necessary" a procedure proposed for pain relief for a patient who has little to no chance of benefitting from the procedure.

Many psychological factors are predictive of prolonged pain reports and poor prognosis for pain relief by invasive procedures. Major risk without predicted benefit is illogical.

Thus, the UR MD and the BWC Medical Director look for things in the "psychological assessment" that are rarely, if ever present, which include:

- The presence of catastrophizing, fear avoidance beliefs, anger directed at the employer and/or insurer, or other common emotional reactions that may be contributing to the severity of symptom report and can delay or prevent recovery.
- The presence of a depressive or anxiety disorder is commonly documented, but the SEVERITY of the condition (severity of symptoms) is rarely documented. Outlining diagnostic criteria by which the diagnosis was determined is expected, but rarely present.
- The presence of a personality disorder or substantial personality factors that may be influencing symptom severity and/or prognosis.
- The testing of self-reported symptoms for "validity" (or symptom exaggeration), as recommended by the AMA Guides, 6th Edition, Sections 14.2 and 14.3, and the American Psychiatric Association, DSM-5 Handbook of Differential Diagnosis.
- The presence of central sensitization of pain. The presence of nociplastic pain.
- The presence of somatization as a psychological defense (to what extent are physical symptoms likely a defense against emotional distress).
- A summary listing all the factors present that individually or collectively would predict a suboptimal outcome for invasive treatment with the indication being pain relief.

Each of these has published studies in general medical and orthopaedic journals correlating the presence of these issues with suboptimal or no benefit from procedures whose indication is relief of chronic pain. While one psychosocial factor may not predict a poor surgery outcome, the total number of predictors, each with literature documentation of its effect on outcome, should be carefully considered.

In addition, the psychological assessments frequently say “understands the potential risk and benefit of the procedure”. Psychologists are not expected to know the risk and potential benefit of the specific proposed procedure. However, documenting the patient’s recollection of risk and benefit permits reviewers to verify the accuracy of the patient’s recall. Thus, from the reports submitted to UR and to the BWC a reviewer does not know if the patient’s perception of risk is “no complications” and the benefit is “almost everyone gets dramatic pain relief”, or if the risk is “20-30% complication rate, some of which are serious and permanent” and the benefit is “one out of ten patients describes >50% pain relief, but almost no one stops opioids, or goes back to work”.

The treating physician’s office note requesting certification for the surgery or invasive pain procedure will always say the risks and benefits were discussed, but never states percentages for risks (number needed to harm) or benefits (number needed to treat in published studies). What the patient remembers is not necessarily what the physician said (Sahin 2010, Crepeau 2011, Sherlock 2014, Shlobin 2020).

Again, the evaluating psychologist would not be expected to know the specifics about incidence rates for specific complications, or the published “number needed to treat” rates for “minimal clinically important difference” and for “substantial clinical benefit”, and the “number needed to harm” for specific complications. These statistics

would be available in published literature to the UR MD and the BWC Medical Director. Absent the psychologist independently documenting specifically what the prospective surgical patient remembers about risk and benefit, the UR MD and the BWC Medical Director cannot know, or comment on, whether the patient's perception of risk versus benefit aligns with published literature on the chronic pain related surgical procedure in question in populations with similar demographics, or if the patient's perception is unrealistic.

Thus, the psychological assessments seen by the BWC OMD may "check off a box" on the ODG criteria list, but these are rarely helpful, and they typically **miss** the purpose for which they have been requested.

Now that we have stated the issue, we can examine the published evidence behind these statements.

Surgeons' ability to recognize psychic distress is suboptimal, and hence the need for independent psychological assessment:

The American Academy of Orthopaedic Surgeons (AAOS) officially recommends Early Screening for Psychological Risk for patients with traumatic injuries of the extremities, spine, or pelvis (Keizer 2022, Piuzzi 2021). They suggest a number of validated patient questionnaires to screen for psychosocial issues that hinder recovery for musculoskeletal injuries. Questionnaires for screening for these issues are readily retrievable using internet search engines. Screening by questionnaires indicates which patients most likely have a significant mental health issue, and is meant to guide referrals for evaluation and potentially for mental health care. Screening positive for a mental health issue by questionnaire is not the same as a formal mental disorder diagnosis by a fully trained mental health professional (MD/DO Psychiatrist or PhD Psychologist).

Why does AAOS recommend screening injured patients for psychological risk? Surgeons frequently assume all pain is due to the biomedical model, and surgeons frequently fail to recognize major mental disorders or psychosocial stressors that will hinder or prevent improvement of symptoms (like pain) or function (like return to work). (Grevitt 1998, Daubs MD, 2010, Daubs 2014, Moon 2023). Personality Style tests document that the same personality traits that make good surgeons (attention to detail, ability to stay calm in crisis, intellectual and not emotional decision making, etc. – "Compulsive style" – Doherty 2011) mean surgeons live in their intellectual brain and suppress their emotions, so they are less prone to recognize emotional stress in their patients.

The correlation of Pre-Operative psychological factors and suboptimal surgical outcomes has been shown for lumbar surgery (Halicka 2022, Serrano-Garcia 2020, Suri P 2017, Dorow 2017, Menendez 2014), lumbar surgery and spinal cord stimulation (Celestin 2009), musculoskeletal pain (Vranceanu 2009, Vargas-Prada 2015), total joint arthroplasty, ACL reconstruction, and spine surgery (Flanigan 2015), foot & ankle surgery (Henry 2021), musculoskeletal trauma (Kang 2021, Vranceanu 2014), total hip replacement (O'Connor 2022), total knee replacement (Khatib 2015, Lewis 2015), shoulder surgery (Baker 2022, Vajapey 2020, Gil 2018) and total joint replacement (Hecht 2023).

The study by Moon, et al (2023) evaluated 296 initial evaluation spine patients by use of the Distress and Risk Assessment Method (DRAM). This questionnaire has been validated in multiple languages and cultures and assesses depression symptoms by the Zung Depression Questionnaire (Psychology Tools 2023, Jokelainen 2019) and assesses somatization and somatic anxiety by the Modified Somatic Perception Questionnaire – Georgoudis 2023, Bianchini 2014).

DRAM Categorization

DRAM Score	**Zung Depression Score**	**MSPQ Total Score**
Normal (N)	<17	Any
At risk (R)	17 – 33	<12
Distressed (D)	>33 >17	Any >12

Each patient completed the DRAM questionnaires, and then one of 3 spine surgeons assessed each patient's spine problem, made a treatment plan, and then also guessed how the patient would score on the DRAM. 129 of the 296 patients had a normal DRAM, and 51.8% of them were labelled correctly as "normal" by the surgeons. 120 patients were in the DRAM "at risk" group, and 44% of them were correctly labelled by the surgeons, but 35.8% of them were classified as "normal" by the surgeons. The most critical group to recognize are the "distressed" group by the DRAM, and of the 47 patients in this category 47% were correctly recognized by the surgeons, but they classified 9.2% normal. This occurred while the surgeons knew they were in a study of surgeons' ability to recognize mentally stressed patients, so this should represent better accuracy than surgeons not being studied. These results were similar to those in 5 other published studies with 22% to 33% of spinal pain patients being in the most severe "distressed" category, and surgeon accuracy of assessment varying from 29% to 69%. The surgeons' overall reliability in this study comparing their assessment to the patients' DRAM was a kappa of 0.13 indicating minimal agreement with a strong bias toward under-recognition of patients' mental stress burden. The surgeons were statistically less likely to recommend surgery for those patients they did recognize as distressed. The patients with DRAM scores indicating "at risk" or "distressed" had more disability (by Oswestry Disability Index for the low back pain patients or the Neck Disability Index for the neck pain patients). Based on the other studies (Daubs 2010), the surgeons' years of experience in practice did not improve their accuracy in assessing patients' stress levels. Multiple studies have documented the ability of the DRAM classification to predict the outcome of spine surgery (Pollock 2012, Jackson 2020, Serrano-Garcia 2020).

ANGER DIRECTED TOWARD THE EMPLOYER/INSURER

If a patient remains angry at the employer or third party over the circumstances that resulted in his injury, or at the insurer over workers' compensation claim handling the Injustice Experience Questionnaire (AAP 2023, Scott 2015) can identify this anger, that impairs or prevents recovery. Ongoing residual anger, whether "justified" or not, is one of the strongest predictors of poor post-surgical outcomes and failed pain procedures (Reme 2022, Ikemoto 2019, Sullivan 2008). Psychiatrists and psychologists work with patients to diffuse residual anger, as they quote the saying variously attributed to Alcoholic Anonymous, Nelson Mandela, etc. "Holding on to anger is like drinking poison and expecting the other person to die". Although anger directed at a perceived transgressor is not a diagnoseable condition, it may nevertheless respond to cognitive behavioral therapy or other mental health intervention.

In preparation for a 2023 BWC sponsored conference a search of the web sites for 4 "orthopaedic journals" using the word "anger" yielded 223 article citations in Journal of Bone and Joint Surgery, 23 citations in Journal of the American Academy of Orthopaedic Surgeons, 38 citations in Spine, and 243 citations in The Spine Journal. Not all of these cited articles are related to persistent anger in patients (some are anger in health care providers, and some even are "anger" in musculoskeletal tissues).

CATASTROPHIZING

Catastrophizing is conceptualized as having an exaggerated negative orientation toward noxious stimuli, negative expectations, increased accessibility of previous memories of pain, worry, and inability to cope effectively with pain (Sullivan 1995, Osman 2000, Ranger 2020). This can be oversimplified as Dorothy, the Tin Man, and the Scarecrow

who feared that there were “lions, and tigers, and bears, oh my” everywhere they went in the Wizard of Oz movie. Importantly, catastrophizing does not mean that the individual is malingering or is not experiencing pain, but suggests a tendency to overstate negative experiences in a way that is predictive of poor outcomes. The questionnaire is 13 questions scored by the patient from 0 to 4, so the total score possibilities are 0 to 52. A score of ≥ 30 is usually considered very significant. Patient responses vary slightly by country and culture (Hayashi 2022). Surgeons will frequently fail to recognize this issue (Sabo 2019). Symptoms of depression and catastrophizing combine to significantly affect outcomes of spine surgery (Menendez 2014) and joint replacement (Springborg 2023, Hardy 2022, Lewis 2015). Poor mental health and catastrophizing are associated with knee replacement outcomes (Olsen 2023).

A search of the web sites for 4 “orthopaedic journals” (not psychology journals) using the word “catastrophizing” yielded 99 article citations in Journal of Bone and Joint Surgery, 27 citations in Journal of the American Academy of Orthopaedic Surgeons, 153 citations in Spine, and 378 citations in The Spine Journal, so the effect of this concept on musculoskeletal injury and surgery is very well researched. A systematic review of 85 studies is available (Martinez-Calderon 2019).

FEAR AVOIDANCE BELIEFS

Kinesiophobia, or fear avoidance beliefs are derived from the concept that injuries produce pain, and the injured person extrapolates to the false concept that “if I feel pain during activity after injury, I must be causing further injury to myself”. Most athletic locker rooms have the exact opposite message posted – a sign stating simply “No pain, no gain”. Rehabilitation after injury or surgery involves activity that is frequently painful, but some patients are so afraid of injury or reinjury that they are unwilling to challenge themselves with activity required to gain strength, endurance, flexibility, etc.

A search of the web sites for 4 “orthopaedic journals” using the words “fear avoidance” yielded 100 article citations in Journal of Bone and Joint Surgery, 38 citations in Journal of the American Academy of Orthopaedic Surgeons, 380 citations in Spine, and 265 citations in The Spine Journal, so the effect of this concept on musculoskeletal injury and surgery is very well researched.

The patient questionnaires that assess the degree of this false belief in patients are Gordon Waddell’s Fear Avoidance Beliefs Questionnaire, or the Tampa Kinesiophobia Scale. The Fear Avoidance Belief Questionnaire has 5 questions in the subsection on Physical Activity, each scored 0-6 so the maximal score is 30. The Work subsection has 11 questions with a maximal score of 66. Cut point for low back pain patients in physical therapy are described (George 2008) as >14 for Physical Activity and > 29 for the Work section.

The Tampa Kinesiophobia Scale originally had 17 questions, but a newer 13 question form has been psychometric statistics. Each question is scored 0-4 so the newer form maximal score is 52. Moderate (scores of 33-42) and Severe (scores of 43-52) are particularly concerning (Neblett 2015). A systematic review of the 41 publications on all the versions was recently published (Dupuis 2023).

A systematic review of 31 kinesiophobia treatment studies found this to be treatable with improvement by psychological treatment and by multimodal treatment that includes both psychological treatment and physical therapy (Huang 2022).

While fear of reinjury is common, and most work-related injuries are not life or limb threatening, and thus don’t meet the DSM5-TR criteria for a Category A PTSD exposure, a number of patients with work injuries are diagnosed with Post-Traumatic Stress Disorder (PTSD). PTSD like symptoms after non-life or limb threatening injury are associated with chronic musculoskeletal pain and disability

(Jadhakhan 2023). This symptom profile is better captured as either a normal response to a stressful circumstance or, if criteria are met, as an Adjustment Disorder.

PRESENCE AND SEVERITY OF DEPRESSION SYMPTOMS/DISORDER AND THE PRESENCE AND SEVERITY OF ANXIETY SYMPTOMS/DISORDER

The best and most recent epidemiologic study of anxiety and depression in the United States used the pre-Covid 2019 National Health Interview Survey of almost 32,000 U.S. adults (De La Rosa 2024), that was then adjusted statistically to mirror the entire population of 244 million U.S. adults. Cut point scores ≥ 10 on the GAD-7 and/or the PHQ-8 questionnaires were used to define a moderate or severe level of chronic anxiety or depression. The prevalence of either anxiety or depression in adults was: without chronic pain 4.9%, and with chronic pain 23.9%. In U.S. adults, 20.5% had chronic pain. In adults with BOTH anxiety and depression 61.3% had chronic pain, and 41% had high impact chronic pain. Compared with those with only chronic pain only, people with anxiety or depression symptoms and chronic pain were approximately 3.0 times more likely to report difficulty doing errands alone, 3.5 times more likely to report difficulty participating in social activities, and 1.6 times more likely to report that work is limited.

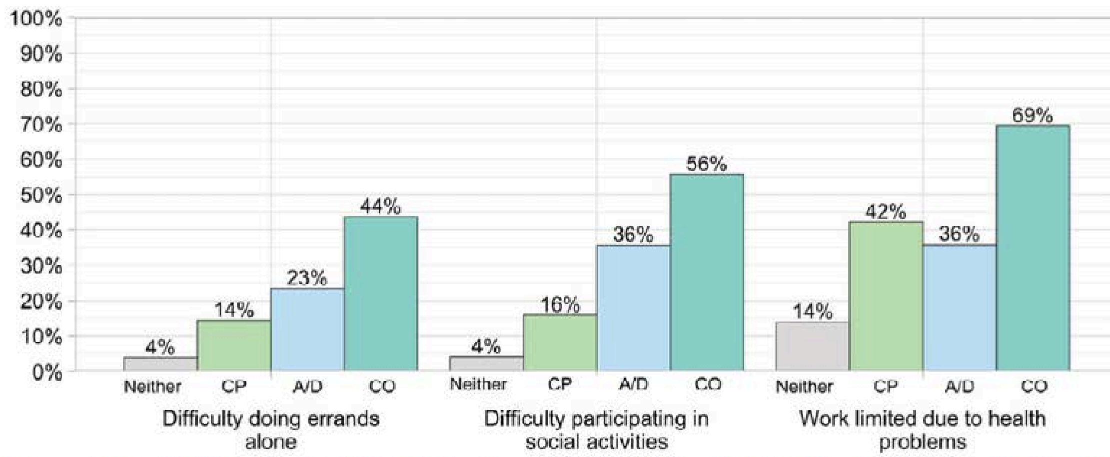

Figure 2. Visualizing prevalence of functional disparities among US adults who have chronic pain only, depression and/or anxiety symptoms only, and co-occurring symptoms. A/D, anxiety/depression only; CP, chronic pain only; CO, co-occurring chronic pain and anxiety/depression symptoms; Neither, neither chronic pain nor anxiety/depression symptoms are present. Data Source: National Center for Health Statistics, National Health Interview Survey, 2019.

Depression and anxiety symptoms are common in patients with injuries and in patients with pain that persists after injuries heal, both before and after musculoskeletal surgery. A study of Texas workers' compensation patients out of work at least 4 months with low back pain found 65% of these patients had a mood (anxiety and/or depression) disorder, or a substance use disorder, while the population-based estimate was they would have a 15% prevalence, or an odds ratio of 10 for a mood disorder or substance use disorder compared to the population at large (Dersh 2006).

A systematic review of 24 published studies (Chen 2021) found that the prevalence of depression (either by structured interview or by self-report questionnaire) before spine surgery was 31% and after spine surgery was 27%, with depression predicting suboptimal outcomes. An earlier systematic review (Strøm 2018) of 14 studies found one-third of spine surgery patients had pre-operative anxiety and depression symptoms, or 2 to 3 times the prevalence of these symptoms in the general population. The most recent systematic review (Davey 2023) is on depression and anxiety and suboptimal rotator cuff repair outcomes.

Psychological assessments frequently state "depression (or anxiety) appropriate to psychosocial circumstances, and under appropriate treatment." Most often, however, the assessments appear not to appreciate that the literature on anxiety and depression and suboptimal results from invasive treatment for pain correlates the suboptimal outcome to the **presence** of the disorder (diagnosis), or to the presence of anti-depressive medication or anti-anxiety medication, and **NOT** to the appropriateness of the symptoms or of the treatment (Harris 2020, Jimenez-Almonte 2020). The severity of the anxiety and/or depressive symptoms also correlates with poor outcomes.

PRESENCE OF A PERSONALITY DISORDER

Personality Disorders are defined in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM5-TR 2022) as “A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the norms and expectations of the individual’s culture, is pervasive and inflexible, **has an onset in adolescence or early adulthood**, is stable over time, and leads to distress or impairment.” These are developmental disorders and not caused by events in adult life. There is quite a lot published about how these 10 disorders can affect the outcomes of bariatric surgery, cosmetic surgery, and transplant surgery, but much less published about how these affect the outcome of the common musculoskeletal disorders. Part of the rationale for not including this assessment in “psych clearance” exams is assessing for the presence of these disorders is very time and labor intensive for psychiatrists and psychologists. One of the few musculoskeletal condition studies is from PRIDE, a musculoskeletal rehabilitation unit in Dallas, TX that treats Texas Workers’ Compensation patients (Dersh 2006). They published on the initial formal psychologist evaluation of 1323 patients with back injuries who were still off work at least 4 months after injury. **70%** of these 1323 patients had a formal Personality Disorder diagnosis, while estimate from the general population was a 15% prevalence. The odds ratio for personality disorder for those off work due to back injury was 13.

The new systematic review (Qurik 2023) of Personality Disorders and Musculoskeletal Disorders found 57 relevant publications. Fibromyalgia, arthritis, and chronic back and/or neck disability were clearly correlated with personality disorders.

VALIDITY OF SELF-REPORTED SYMPTOMS

Essentially all of these studies on psychological factors affecting the outcome of chronic pain after musculoskeletal injury and surgery report that those with the most severe chronic pain have the highest rate of suboptimal outcomes from treatment. Of particular concern is the **chronic** pain patient who walks into the physician's office exam room and states their pain is "10" out of 10 on a 0 to 10 pain intensity scale. That level of pain is only seen occasionally in the Emergency Department in patients with severe multiple body part injury or life-threatening disease. A series of 160 consecutive U.S. *chronic* spinal pain patients (Behrend 2017) who stated at their initial spine clinic evaluation that their chronic pain was a "10" (2.9% of the 6779 new spine pain patients seen) were followed. The authors operated on 1 of the 160 patients, suggesting this level of pain correlates with psychosocial factors and not with the severity of physical pathology. Those who improved with non-operative treatment were less likely to be young, to have identified secondary gain, and *less* likely to be smoking.

PRESENCE OF SOMATIZATION

Somatization is considered a defense against psychological stress in which physical symptoms are "substituted" for psychological ones. We can think of it as the adult version of children who are anxious about going to school and develop a stomachache instead. The stomachache is a real physical symptom, but it is better explained by psychological distress than any underlying physical pathology. Somatization often explains the conundrum of symptoms for which there are no clear physical disease or injury explanations, particularly if there is psychological testing or other information that suggests the presence of this ego defense mechanism. Importantly, physical symptoms arising from somatization are rarely improved by pain procedures (Celestin 2009, Giesinger 2013, Bierke 2016, Sorel 2019,

Bierke 2020, Schneider 2021). Multiple well known psychological tests have a scale to assess somatization, including the Patient Health Questionnaire-15 (PHQ-15), (Kocalevent 2013 Kroenke 2002), scales of the Personality Assessment Inventory (PAI), and scales of the Minnesota Multiphasic Personality Inventory (MMPI-2, MMPI-2-RF, or MMPI-3).

MEDICAL RECORDS MAY INJURE PEOPLE

Physicians and psychologists should be aware that their words and diagnoses can injure patients (Barsky 2017). Patients today have a legal right to their medical records, and due to the large number of errors in electronic medical records today perpetuated by “copy and paste”, injured workers with attorneys are not infrequently given a copy of their medical records with instructions to read them and mark for the attorney the errors the patient finds. This helps create the “I’m ruint, I can never work again, I have 3 bulged discs in my back” syndrome. The patient is not aware that bulging discs with no nerve root compression are an aging change (like gray hair) and are not statistically associated with back pain, other than pain is more prevalent as we age. They reflect aging and not symptomatic pathology. Similarly, if patients read a psychological assessment following a simple lifting related back strain (not a category A criterion event for the diagnosis of PTSD), some will remark, “I’m ruint, I can never work again, I have PTSD and Major Depression, and Generalized Anxiety – 3 mental illnesses that the internet says are frequently permanent.”

In general medicine, we don’t see rheumatologists diagnose Lupus and Rheumatoid Arthritis, and Mixed Connective Tissue Disease in the same person. While the patient may have features of each, the doctor is expected to pick the one that best fits the disease symptoms and findings. While a patient may meet criteria for multiple medical illnesses, it is likely best to pick the disorder that best conceptualizes the symptoms.

By contrast, in psychological records and reports, we often see multiple diagnoses without an apparent effort to best characterize the primary problem. Also worth considering is the fact that some diagnostic labels, when used inappropriately and without clearly meeting criteria, are seen by patients to imply substantial pathology beyond what is warranted. If the injured worker reads their medical records, and then researches the internet, Adjustment Disorder is less threatening and is frequently listed as temporary, not permanent. This likely more accurately describes the onset of mental symptoms after physical injury, unless the facts fit with PTSD. Similarly, Adjustment Disorder with Depressive Symptoms may better capture generalized "depression" that does not meet criteria for a Major Depressive Disorder, and is less pathologizing.

The American Psychiatric Association publishes the DSM5 & DSM5-TR but also publishes a companion text DSM-5: Handbook of Differential Diagnosis (First 2014). First year medical students are taught differential diagnosis – start with a symptom or problem, for example jaundice, and list all the conditions that might cause this problem. Then systematically eliminate those that are not likely based on further information, until the likely correct diagnosis is established. The 6-step process for mental diagnosis in the APA companion text is:

1. Rule out Malingering and Factitious Disorder
2. Rule out Substance Etiology (including drugs of abuse and medications)
3. Rule out a Disorder Due to a General Medical Condition
4. Determine the Specific Primary Disorder(s)
5. Differentiate Adjustment Disorders from the residual of other specific unspecified disorders.
6. Establish the Boundary with NO mental disorder.

The psychological assessments for surgical “clearance” in chronic pain patients seem most often to only include step 4, and not specifically state that these other steps have been considered. Since all mental disorders are currently diagnosed by self-reported symptoms, the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition, page 351 states “It is standard practice that a neuopsychological test battery should include instruments that include 2 symptom validity tests.” The invasive pain procedure psychological assessments typically fail to validate the history of mental symptoms and physical symptoms by psychological testing.

SUMMARY

What the BWC typically sees in psychologist assessments prior to an invasive pain procedure is an evaluation that states the patient is not psychotic, has depression or anxiety symptoms (and frequently diagnoses) that are being treated, has the legal ability to make decisions about their health care, and understands the risks and benefits of the proposed procedure. This typically misses the reason that guidelines, insurers, utilization reviewers, and the BWC Medical Director want to see a psychologist assessment.

Multiple validated questionnaires are in the public domain and easy to use to assess anxiety, depression, catastrophization, fear avoidance beliefs, unresolved anger, central sensitization, chronic opioid hyperalgesia, and somatization. Each of these is an independent established risk factor for suboptimal outcomes, and the more of these that are present in a single patient-candidate for invasive pain procedures, the chances of a successful pain related procedure decrease. Ultimately, what is needed for psychological “clearance” is a comprehensive assessment of the psychological and psychosocial risk factors that may yield suboptimal outcomes and/or substantial harm to the patient, and not simply a diagnosis coupled with a “check-the-box” approval.

*Jump to **references** for this article.*

Interview with Psychiatrist Greg Kyser, MD

Interview with Psychiatrist Greg Kyser, MD

Greg Kyser, MD

Psychiatrist Greg Kyser, MD, of Nashville TN accepts workers' compensation patients. He is a CPP Physician and MIR Physician and is available for treatment and evaluations in a virtual setting. He has been board certified in psychiatry by the American Board of Psychiatry and Neurology since 1993. He is a graduate of the University of Arkansas and completed medical training at the University of Arkansas for Medical Sciences. He completed a master's degree in clinical psychology from Trinity University. He has been in private practice in Nashville since completing psychiatric training at Vanderbilt University Medical School in 1991.

AdMIRable Review: *Thank you for taking the time from your busy schedule to answer a few questions, Dr. Kyser. Since you are one of the few psychiatrists who treats workers' compensation patients in Tennessee, it's been said that you are single-handedly saving the workers' compensation system. Why do you think there aren't more psychiatrist involved in the Tennessee workers' compensation system?*

Greg Kyser, MD: While I appreciate the compliment, I'm not sure that is completely accurate. There are a number of psychiatrists and other mental health providers that are involved in treating injured workers. Having said that, there is clearly a shortage. There is a significant shortage and the Bureau of Workers' Compensation and the Tennessee Psychiatric Association is attempting to deal with the issue proactively. I've been trying to compile a list of providers as I review other cases.

I don't think there is a simple answer as to why mental health providers are reluctant to participate, but the clear and overriding factor is the burden of dealing with the workers' compensation system. It is a complex, bureaucratic system, that can be hard to navigate. At times, it seems as though the system is adversarial to the treating physician. Denials, underpayments, inappropriate PPO

discounts and excessive paperwork are frequent headaches for the treating physician.

> What is not well known, is that the Tennessee workers' compensation fee schedule is extremely fair and has recently been enhanced by the Bureau for board-certified psychiatrists.

Stigma is an issue. Many physicians have had negative experiences with patients perceived to be malingering or exhibiting symptom magnification. Although that can be an issue in treatment, it is not common. The vast majority of injured workers that I have treated have been legitimately injured and have received necessary and indicated treatment. A recent survey indicated that the majority of psychiatrists do not participate in private healthcare PPO networks and the workers' compensation system is likely seen as even more burdensome.

Many physicians, including psychiatrists, are not trained in the skills needed to treat injured workers such as dealing with case managers, adjusters and often times attorneys. Concepts such as maximum medical improvement and skills such as performing impairment ratings require training above and beyond that given to resident physicians.

AR: *Overcoming stigma and getting the word out about the new enhanced workers' compensation fee schedule are big challenges for us at the Bureau. How do you feel about our new Certified Physician Program? You've recently been appointed to the CPP Registry. Is there anything the Bureau can do to make the program better for psychiatrists?*

GK: I believe the CPP is a game changer for workers' compensation providers in Tennessee. It offers a standardized training program that allows providers to establish credentials and rewards them for doing so. So far, the challenge has been to communicate to adjusters and workers' compensation carriers the specifics of the program and the

utilization of the enhanced “Z codes” for additional reimbursement. The majority of our submissions of these codes we have submitted have initially been rejected, then paid after a reminder is sent. As it is a program that is specific to the state of Tennessee, I'm not sure how the Bureau can improve on this. It may just take multiple claims, "going through the wash." Anything that could be done proactively by the Bureau would be most helpful. On the backend, the Bureau has been exceedingly helpful in offering assistance in such cases.

AR: *We will definitely look into ways to better facilitate the payment process with the enhanced fees for CPP Physicians. You’ve mentioned that the medical fee schedule for workers’ compensation is fair. Beyond renumeration, are their other compelling reasons why psychiatrists and other mental health professions should consider accepting workers’ compensation patients?*

GK: There are a variety of reasons that one might participate in the WC system. The most compelling is an opportunity to help workers that have typically been seriously injured and are struggling to both cope with those injuries and to return to the workplace. Psychiatric conditions often times are chronic problems leading to the need for long-term maintenance care. I find that the opportunity to make a real difference in an injured workers life and to assist them in either returning to gainful employment or helping to facilitate deserved compensation for the injury can be very rewarding.

The treatment of injured workers requires one to operate in a system that is different from routine psychiatric care and presents different challenges and an opportunity to utilize a multitude of skill sets beyond those of routine practice.

Also, I personally enjoy the interactions with the legal profession and the opportunity to express and defend opinions related to causality and impairment.

AR: *We are thrilled that you accept workers' compensation, Dr. Kyser, and we know a lot of injured workers, employers, and insurance carriers are grateful too. It's nice to know that there are possible intrinsic rewards for treating workers' compensation patients, in addition to extrinsic rewards that are so often mentioned. Thank you for your time today, for sharing with us your insightful opinions, and for accepting workers' compensation patients. It's our hope that other psychiatrists and mental health professionals will follow your example.*

Injured Workers Need Your Assistance

Injured Workers Need Your Assistance

Robert. B. Snyder, MD, Medical Director, Tennessee Bureau of Workers' Compensation James B. Talmage, MD, Assistant Medical Director

Robert. B. Snyder, MD (left) James B. Talmage, MD (right)

INTRODUCTION

It is no longer unusual for the news to carry stories about robberies or other traumatic events in our community or our state occurring to workers, such as the shootings at McDonald's in Antioch, Kroger's in Germantown, or the Covenant School in Nashville. Whether or not they are physically injured, the effect on individuals in that work environment can be profound and life-altering. As a result, many individuals develop acute stress disorder and/or PTSD that can be directly related to a traumatic event in the course and scope of their employment. Therefore, their treatment is covered by the employer's workers' compensation insurance. Finding timely and competent treatment under the limitations of workers' compensation has been difficult. I cannot change the law but would like to see what we might do to help these persons get the mental health care they need and deserve. The purpose of this article is to try to overcome some of the resistance of Psychiatrists to accept and treat these individuals.

Many, if not most, Psychiatrists do not accept assigned insurance and require payment at the time of service. There should be acceptable ways to get payment in a timely manner when treating these patients that will not burden you or your staff. We have received several complaints and we hope to offer some potential solutions to allay some of the issues.

TREATMENT

Early and effective treatment provides the best possibility of a good outcome, whether it means returning to the same employer/circumstance or eventually just returning to as close to a normal enjoyment of life as possible. So, the availability of enough physicians to accept these patients is important. Delay in treatment is one of most important reasons for a poor outcome.

Granted, these patients are hard to treat. They feel victimized by both the event and by the "system." They may not express their reluctance to return to the situation either emotionally or physically and may not be honest about their circumstances. In addition, you are viewed with suspicion as the "company doctor", not keeping their best interest as the most important aspect of your treatment. It takes extra time and effort to overcome the barriers of victimhood and suspicion.

COMMUNICATIONS

This is compounded by poor initial (and subsequent) communications with the patient from their employer, the insurance adjuster, and the case manager. Also, there is often the same problem of poor communication by the adjuster and the case manager with the treating Psychiatrist. Their goals are sometimes at odds with the needs of the patient. The Bureau provides training programs for adjusters and case managers to try to improve their communication skills, empathy, responsiveness, timeliness, and honesty. Unfortunately, the system does not allow the adjusters to have a reasonable workload to be able to efficiently and timely read some of your notes or other materials. This compounds your reluctance to treat these patients.

TRAINING

The Bureau has provided a special educational initiative for physicians that gives training on the best practices for treating injured workers, called the Certified Physician Program (CPP). These sessions include how to communicate with stakeholders and what is required for these patients including causation, return-to-work slips and assessing maximum medical improvement. These sessions are online, can be viewed at your convenience and provide 10 hours of free CME, AMA Category 1 Credit®. Special arrangements can be made for the

impairment guides training for your specialty. Once certified through this program, you receive extra reimbursement. More information can be found at Certified Physician Program.

WORK STATUS

Questions about work status may not be appropriate during initial treatment visits but are a legislatively established requirement of the employers/insurers that permits the workers, that are unable to work, to receive wage replacement benefits. Having a form and completing it at each visit so that it can accompany the records (and be given to the injured worker and the case manager) is the best way to solve this dilemma. If it would be helpful, we can work with you to develop an example form specifically for psychiatric treatment and to include the next appointment date and time. You should also be aware that the insurer's expectation is that you will forward a copy of your treatment notes to the insurer with your bill for each session.

APPOINTMENT PROCESSES

Appointment issues can be solved but they do take some forethought and education of your staff. When an appointment is made for a new patient covered under workers' compensation, being clear about the expectations from the person making the appointment is important.

Intake office staff questions when scheduling an initial appointment for this group of patients, should have a form just like your questions about past history:

1. Is this a visit for causation determination? Ongoing treatment?
2. Is this an Independent Medical Examination? Are you not expected to treat?
3. Has the patient received prior or other mental health treatment? If so when and by whom?

4. Is this visit to take over the mental health care of the patient?
5. Who is responsible for payment?
6. For ongoing treatment, has there been any change in the patient's adjuster or claim status (ask at each visit)?

PAYMENTS

For your satisfaction and protection, a written agreement (contract) with the adjuster may help and might include clarity about such issues as specific payment amounts for your codes (that are not subject to discounts), timeliness and timeframe of payments, timely notification of adjuster changes, timely notification of cancellations, claim status changes, follow-up appointments, extra questions, understanding about case managers, records requests, determining treatment outcomes, opining on maximal medical improvement and permanent impairment-there are statutory rules about these issues that require some extra education.

FOCUS OF TREATMENT

When treatment notes indicate psychosocial stressors pre-existing and unrelated to the workplace incident become the focus of treatment, insurers are reluctant to continue paying for ongoing treatment. Notes and treatment should focus primarily on work-related events or notes should reflect how the current treatment is related to the covered injury.

RELUCTANCE

The workers' compensation fee schedule maximums pay a premium over Medicare (180%) but we suspect that payment is not what keeps most Psychiatrists from accepting these patients. You already have enough to do, and the extra hassles of billing, collections, questions, and interference probably rank higher than the level of payment.

There is also the evidence of poorer response to treatment and delayed outcomes that make Psychiatrists reluctant to take on these patients.

However, they do need good physicians to undertake their care. We at the Bureau are willing to meet with any of you in groups, or one-on-one, to exchange and provide more information. We hope to encourage you to explore the possibility of helping with these deserving individuals.

MIRR Doctor’s Mental Injury Rating Affirmed on Appeal

MIRR Doctor's Mental Injury Rating Affirmed on Appeal

By Jane Salem, staff attorney, Nashville

Jane Salem

The Appeals Board recently released an opinion reviewing an impairment rating for a mental injury involving the Medical Impairment Rating Registry, affirming the trial court's acceptance of that doctor's rating. The Board also gave valuable guidance about the apportionment of ratings.

In *Savitri Matthews v. Family Dollar Stores of Tennessee, LLC,* the employee was working as a cashier when a man entered and held her at gunpoint to rob the store. When the gunman heard her coworkers in other parts of the store and realized she wasn't alone, he cocked his weapon and demanded that they come to the front of the store. She gave the gunman money from the register, and he fled.

Afterward, Family Dollar directed Matthews to see Dr. Greg Kyser, a psychiatrist, who treated her for PTSD and depression for several months. He eventually assigned a ten-percent rating. Matthews then underwent an employer's evaluation with Dr. Stephen Montgomery, who gave a ten-percent rating but apportioned it to conclude that 2.5 percent of that rating was from the work incident. So the parties sought a rating from Dr. Melvin Goldin through the Rating Registry. He placed a ten-percent rating.

At trial, Family Dollar argued that Dr. Montgomery's rating was correct. It asserted that other traumatic events in Mathews's life contributed to her impairment. Specifically, before the robbery, she was diagnosed with cancer; a close family member molested her teenage daughter; and she filed for bankruptcy. After the robbery, her home was destroyed by a tornado while both she and her daughter were inside it; her college-age son died unexpectedly; and she had a major car accident and stroke.

For her part, Matthews testified that the robbery's impact on her mental health was different from the other traumatic life events

because the gunman made an intentional choice to hold her at gunpoint and frighten her repeatedly.

The trial court found that testimony credible and concluded that, by apportioning the rating, Dr. Montgomery improperly considered post-incident traumatic events. Instead, the Court accepted the two opinions that carry presumptions and awarded benefits based on their ratings.

THE OPINION

On appeal, Family Dollar argued Dr. Goldin was unable to conclude within a reasonable degree of medical certainty which percentage of the impairment was directly attributable to the work incident, so his written report was invalid.

Ms. Mathews's counsel conceded that Dr. Goldin had reviewed the wrong patient's report before the deposition, so some of his responses were based upon incorrect information. But he knew about the other traumatic events and had the necessary information to determine her rating under the AMA Guides. His rating never changed, and Dr. Goldin testified that only traumas before the work incident were to be considered in apportionment.

With regard to Dr. Montgomery's apportionment, the trial court had reasoned that events after the robbery should not have been considered. In a footnote, the Board gave an important opinion on the interplay between causation, impairment, and apportionment:

Although we agree that apportionment, as that term is used in the AMA Guides, relates to determining the degree of permanent medical impairment arising from a work-related incident as compared to one or more preexisting impairments, we do not agree that subsequent events are necessarily irrelevant. In cases where a mental injury is alleged, for

example, subsequent traumatic events experienced by an injured worker may constitute one or more independent, intervening causes of psychiatric impairment. This is certainly a factor a trial court can consider in the context of causation. Stated another way, pre-existing impairments can be considered by an evaluating physician when apportioning impairment ratings in accordance with the AMA Guides, and subsequent impairing events can be considered by the court in its causation analysis. Both can be relevant and appropriate to consider in any given case, and testimony regarding subsequent traumas may also impact the employee's entitlement to future medical benefits.

The Board wrote that the trial court determined that all three physicians are well-qualified and used the same methodology in the Guides to calculate their ratings. Therefore, the presumptions played a significant role.

Family Dollar contended no presumption attaches to Dr. Kyser's opinion because he wasn't selected from a panel. The Board disagreed, pointing out that the panel requirement applies to an authorized physician's causation opinion.

As a Rating Registry physician, Dr. Goldin's rating can only be rebutted by "clear and convincing evidence," while Dr. Kyser's opinion is presumed correct as the treating physician but can be rebutted by "a preponderance of the evidence." Dr. Montgomery's opinion met neither standard. So, the Board concluded the trial court didn't err in determining that both Dr. Kyser's and Dr. Goldin's impairment ratings were entitled to their respective statutory presumptions, and the ten-percent rating was correct.

Interestingly, during cross-examination, Dr. Kyser was asked if he believed an inherent conflict exists in being an injured employee's treating psychiatrist and providing expert testimony on behalf of that employee. This is sometimes referred to as "treater's bias."

In response, Dr. Kyser stated that there are only "a handful of psychiatrists in Tennessee that practice workers' comp and that know how to do this." (He's correct, unfortunately.) He added that the Guides require him to address impairment when he places patients at maximum medical improvement. He stated that his credibility as well as the weight of his opinion are factors for the trial court to consider.

The trial court had acknowledged that the Guides suggest that a treating provider should generally avoid serving as an expert witness on behalf of a patient, "mainly because it could be detrimental to their therapeutic relationship." But the court reasoned that both Dr. Kyser and Matthews were aware that he'd be asked to testify. Moreover, Dr. Kyser observed that the statute requires him to assign an impairment rating.

This was the first case where a Rating Registry doctor's impairment rating for a mental injury was reviewed by an appellate court. But the opinion carries weight in any future case where the parties dispute impairment for a mental injury and illustrates the fine line between medical causation and impairment in these cases.

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REFERENCES

References for the “Psychologic Assessment for Chronic Pain Procedures” article:

- AAP 2023: chrome-extension: efaidnbmnnnibpcajpcglclefindmkaj/file:///C:/Users/DtT/Downloads/injustice%
- Baker M, Albelo F, Zhang T, et al. PROMIS Depression and Anxiety in shoulder surgery patients. The Bone and Joint Journal 2022. 104-B (4): 479-485. doi: 10.1302/0301-620X.104B4.BJJ-2021-1089.R1. PMID: 35360950
- Barsky AJ. The Iatrogenic Potential of the Physician’s Words, JAMA. 2017;318(24):2425-2426. doi:10.1001/jama.2017.16216

- Bianchini KJ, Aguerrevere LE, Guides B, et al. Accuracy of the Modified Somatic Perception Questionnaire and Pain Disability Index in the Detection of Malingered Pain-Related Disability in Chronic Pain. The Clinical Neuropsychologist 2014; http://dx.doi.org/10.1080/13854046.2014.986199 DOI: 10.1080/13854046.2014.986199.
- Bierke S, Häner M, Petersen W. Influence of somatization and depressive symptoms on the course of pain within the first year after uncomplicated total knee replacement: a prospective study. Int Orthop. 2016 Jul;40(7):1353-60. doi: 10.1007/s00264-015-3105-z.
- Bierke S, Häner, Karpinski K, et al. Midterm Effect of Mental Factors on Pain, Function, and Patient Satisfaction 5 Years After Uncomplicated Total Knee Arthroplasty. J Arthroplasty 2020 Jan;35(1):105-111. doi: 10.1016/j.arth.2019.08.008.
- Behrend CJ, Schönbach EM, Vaccaro AR, et al. Maximum pain on visual analog scales in spinal disorders. The Spine Journal 17 (2017) 1061–1065 doi: 10.1016/j.spinee.2016.11.017
- Celestin J, Edwards RR, Jamison RN. Pretreatment psychosocial variables as predictors of outcomes following lumbar surgery and spinal cord stimulation: a systematic review and literature synthesis. Pain Med 2009;10(4): 639-53. doi: 10.1111/j.1526-4637.2009.00632.x.
- Chen Z, Luo R, Yang Y, et al. The prevalence of depression in degenerative spine disease patients: A systematic review and meta-analysis. Eur Spine J 2021; 30 : 3417-3427 https://doi.org/10.1007/s00586-021-06977-z
- Crepeau AE, McKinney BI, Fox-Ryvicker M, et al. Prospective evaluation of patient comprehension of informed consent. J Bone Joint Surg Am 2011 Oct 5;93(19):e114(1-7). doi: 10.2106/JBJS.J.01325.
- Daubs MD, Patel AA, Willick SE, et al. Clinical Impression Versus Standardized Questionnaire: The Spinal Surgeon’s Ability to Assess Psychological Distress. J Bone Joint Surg Am. 2010;92 (18):2878-83 d doi:10.2106/JBJS.I.01036

- Davey MS, Davey, MG, Hurley ET, et al. The Effects of Pre-existing Mood Disorders on Patient-Reported
- Outcomes After Arthroscopic Rotator Cuff Repair: A Systematic Review and Meta-analysis. JBJS REVIEWS 2023;11(10):e22.00187 · http://dx.doi.org/10.2106/JBJS.RVW.22.00187
- De La Rosa JS, Brady BR, Ibrahim MM, et al. Co-occurrence of chronic pain and anxiety/depression symptoms in U.S. adults: prevalence, functional impacts, and opportunities. PAIN 165 (2024) 666–673. http://dx.doi.org/10.1097/j.pain.0000000000003056
- Dersh J, Gatchel RJ, Mayer T, et al. Prevalence of Psychiatric Disorders in Patients With Chronic Disabling Occupational Spinal Disorders. Spine 2006; 31 (10): 1156-1162. doi: 10.1097/01.brs.0000216441.83135.6f.
- Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision. The American Psychiatric Association, 2002, Washington DC, ISBN 978-0-89042-576-3 (Paperback) 1st printing February 2022
- Doherty EM, Nugent E. Personality factors and medical training: a review of the literature. Med Educ 2011; 45: 132-140. DOI: 10.1111/j.1365-2923.2010.03760.x
- Dorow M, Löbner M, Stein J, et al. Risk Factors for Postoperative Pain Intensity in Patients Undergoing Lumbar Disc Surgery: A Systematic Review. PLoS One 2017. https://doi.org/10.1371/journal.pone.0170303
- Dupuis F, Cherif A, Batcho C. et al. The Tampa Scale of Kinesiophobia A Systematic Review of Its Psychometric Properties in People With Musculoskeletal Pain. Clin J Pain 2023;39:236–247. DOI: 10.1097/AJP.0000000000001104
- First MB. DSM-5 Handbook of Differential Diagnosis. American Psychiatric Association Publishing, 2014, Washington DC, ISBN 978-1-58562-462-1
- Flanigan DC, Everhart JS, Glassman AH. Psychological Factors Affecting Rehabilitation and Outcomes Following Elective

Orthopaedic Surgery. J Am Acad Orthop Surg 2015;23: 563-570. http://dx.doi.org/10.5435/JAAOS-D-14-00225

- George SZ, Fritz JM, Childs JD. Investigation of Elevated Fear-Avoidance Beliefs for Patients with Low Back Pain: A Secondary Analysis Involving Patients Enrolled in Physical Therapy Clinical Trials. J Orthop Sports Phys Ther 2008;38(2):50-58. doi:10.2519/jospt.2008.2647
- Georgoudis G, Raptis K, Koutserimpas C. The Modified Somatic Perception Questionnaire (MSPQ): Validation and Cultural Adaption in Greek. Maedica 2023; 18 (1): 74-9. doi: 10.26574/maedica.2023.18.1.74
- Giesinger JM, Kuster MS, Behrend H, Giesinger K. Association of psychological status and patient-reported physical outcome measures in joint arthroplasty: a lack of divergent validity. Health Qual Life Outcomes 2013 Apr 19:11:64. doi: 10.1186/1477-7525-11-64
- Gil JA, Goodman AD, Mulcahey MK. Psychoological factors affecting Outcomes after elective shoulder surgery. JAAOS 2018; 26 (5): e98-e104 DOI: 10.5435/JAAOS-D-16-00827
- Grevitt M, Pande K, O'Dowd J, Webb J. Do First Impressions Count? A comparison of subjective and psychological assessment of spinal patients. Eur Spine J 1998; 7: 218-223. doi: 10.1007/s005860050059.
- Halicka M, Duarte R, Catherall S, et al. Systematic Review and Meta-Analysis of Predictors of Return to Work After Spinal Surgery for Chronic Low Back and Leg Pain. J of Pain 2022; 23 (8): 1318-1342. https://doi.org/10.1016/j.jpain.2022.02.003
- Hardy A, Sandiford MH, Menigaux C, et al. Pain catastrophizing and pre-operative psychological state are predictive of chronic pain after joint arthroplasty of the hip, knee, or shoulder: results of a prospective, comparative study at one year follow-up. International Orthopaedics (2022) 46:2461–2469, https://doi.org/10.1007/s00264-022-05542-7

- Harris AB, Marrache M, Puvanesarajah V, et al. Are preoperative depression and anxiety associated with patient-reported outcomes, health care payments, and opioid use after anterior discectomy and fusion? The Spine Journal 20 (2020) 1167−1175. https://doi.org/10.1016/j.spinee.2020.03.004
- Hayashi K, Ikemoto T, Shiro Y, et al. A Systematic Review of the Variation in Pain Catastrophizing Scale Reference Scores Based on Language Version and Country in Patients with Chronic Primary (Non-specific) Pain. Pain Ther (2022) 11:753–769. https://doi.org/10.1007/s40122-022-00390-0
- Hecht CJ, Burkhart RJ, Karimi AH, et al. What is the Association Between Clinically Diagnosed Psychiatric Illness and Total Joint Arthroplasty? A Systematic Review Evaluating Outcomes, Healthcare Use, and Patient-reported Outcome Measures. Clin Orthop Relat Res 2023;481 (5): 947-964. doi: 10.1097/CORR.0000000000002481.
- Henry JK, Barth K, Cororation A, et al. Association of Depression and Anxiety With Expectations and Satisfaction in Foot and Ankle Surgery. J Am Acad Orthop Surg 2021; 29 (16): 714-722. DOI: 10.5435/JAAOS-D-20-01394
- Huang J, Xu Y, Xuan R, et al. A Mixed Comparison of Interventions for Kinesiophobia in Individuals with Musculoskeletal Pain: A Systematic Review and Network Meta-Analysis. Frontiers in Psychology 2022; 13:886015. doi: 10.3389/fpsyg.2022.886015
- Ikemoto T, Miki K, Matsubara T, Wakao N. Psychological Treatment for Chronic Low Back Pain. Spine Surgery and Related Research 2019; 3(3): 199-206 dx.doi.org/10.22603/ssrr.2018-0050
- Jackson KL, Rumley J, Griffith M, et al. Correlating Psychological Comorbidities and Outcomes after Spine Surgery. Global Spine J 2020; 10 (7): 929-939 doi: 10.1177/2192568219886595.
- Jadhakhan F, Evans D, Falla D. The role of post-trauma stress symptoms in the development of chronic musculoskeletal pain and disability: A systematic review. European Journal of Pain 2023; 27: 183-200. DOI: 10.1002/ejp.2048

- Jimenez-Almonte JH, Hautala GS, Abbenhaus EJ, et al. Spine patients demystified: what are the predictive factors of poor surgical outcome in patients after elective cervical and lumbar spine surgery? The Spine Journal 2020; 20: 1529−1534. https://doi.org/10.1016/j.spinee.2020.05.550
- Jokelainen J, Timonen M, Keinänen-Kiukaanniemi S, et al. Validation of the Zung Self-Rating Depression Scale in Older Adults. Scand J Prim Health Care. 2019; 37(3): 353–357. doi: 10.1080/02813432.2019.1639923
- Kang KK, Ciminero ML. Parry JA, Mauffrey C. The Psychological Effects of Musculoskeletal Trauma. J Am Acad Orthop Surg 2021;29:e322-e329 DOI: 10.5435/JAAOS-D-20-00637
- Keizer BM, Wegener ST. AAOS Clinical Practice Guideline Summary: AAOS/Major Extremity Trauma and Rehabilitation Consortium Clinical Practice Guideline Summary for Evaluation of Psychosocial Factors Influencing Recovery From Orthopaedic Trauma. Journal of the American Academy of Orthopaedic Surgeons 2022: 30 (3): e307-e312. http://dx.doi.org/10.5435/JAAOS-D-21-00777
- Khatib Y, Madan A, Naylor JM, Harris IA. Do Psychological Factors Predict Poor Outcome in Patients Undergoing TKA? A Systematic Review. Clin Orthop Relat Res (2015) 473:2630–2638 DOI 10.1007/s11999-015-4234-9
- Kocalevent RD, Hinz A, Brähler. Standardization of a screening instrument (PHQ-15) for somatization syndromes in the general population. BMC Psychiatry 2013; 13 :91. http://www.biomedcentral.com/1471-244X/13/91
- Kroenke K, Spitzer RL, Williams JBW. The PHQ-15: validity of a new measure for evaluation the severity of somatic symptoms. Psychosom Med 2002 2002; 64 (2): 258-66. doi: 10.1097/00006842-200203000-00008.
- Lewis GN, Rice DA, McNair PJ, Kluger M. Predictors of persistent pain after total knee arthroplasty: a systematic review and meta-analysis. Br J Anaesth 2015; 114 (4): 551-561 doi:10.1093/bja/aeu441

- Martinez-Calderon J, Jensen MP, Morales-Asencio JM, et al. Pain Catastrophizing and Function In Individuals With Chronic Musculoskeletal Pain: A Systematic Review and Meta-Analysis. Clin J Pain 2019;35:279–293. DOI: 10.1097/AJP.0000000000000676
- Mazzucchi E, La Rocca G, Cusumano D, The role of psychopathological symptoms in lumbar stenosis: A prediction model of disability after lumbar decompression and fusion. Front Psychol. 2023 Mar 22;14:1070205. doi: 10.3389/fpsyg.2023.1070205.
- Menendez ME, Neuhaus V, Bot AGJ, et al. Psychiatric Disorders and Major Spine Surgery. Spine 2014; 39 (2): E111-E122. DOI: 10.1097/BRS.0000000000000064
- Moon AS, Menendez ME, Moverman MA, et al. Spine Surgeon Assessments of Patient Psychological Distress are Inaccurate and Bias Treatment Recommendations. Spine 2023: 48 (134): 908-913. DOI: 10.1097/BRS.0000000000004567
- Neblett R, Hartzell MM, Mayer TG, et al. Establishing clinically meaningful severity levels for the Tampa Scale for Kinesiophobia (TSK-13). European Journal of Pain 2016; 20 (5): 701-710. https://doi.org/10.1002/ejp.795
- O'Connor JP, Holden P, Gagnier JJ. Systematic review: preoperative psychological factors and total hip arthroplasty outcomes. Journal of Orthopaedic Surgery and Research 2022; 17:457. https://doi.org/10.1186/s13018-022-03355-3
- Olsen U, Lindberg MF, Rose C, et al. (2023) Factors correlated with pain after total knee arthroplasty: A systematic review and meta-analysis. PLoS ONE 18(3): e0283446. https://doi.org/10.1371/journal.pone.0283446
- Osman A, Barrios FX, Gutierrez PM, et al. The Pain Catastrophizing Scale: further psychometric evaluation with adult samples. J Behav Med 2000 Aug;23(4):351-65. doi: 10.1023/a:1005548801037.

- Pollock R, Lakkol S, Budithi C, et al. Effect of psychological status on outcome of posterior lumbar interbody fusion surgery. Asian Spine J. 2012 Sep;6(3):178-82. doi: 10.4184/asj.2012.6.3.178.
- Piuzzi NS, Ring D. AAOS Appropriate Use Criteria Summary: American Academy of Orthopaedic Surgeons Appropriate Use Criteria: Early Screening for Psychosocial Risk and Protective Factors. Journal of the American Academy of Orthopaedic Surgeons 2021;29 (15): e760-e765 DOI: 10.5435/JAAOS-D-20-00810
- Psychology Tools: Zung Depression Scale - https://psychology-tools.com/test/zung-depression-scale, accessed 10.31.23
- Quirk SE, Koivumaa-Honkanen H, Kavanagh BE, et al Exploring the comorbidity between personality and musculoskeletal disorders among adults: A scoping review. Front. Psychiatry 2023: 13:1079106. doi: 10.3389/fpsyt.2022.1079106
- Ranger TA, Cicuttini FM, Jensen TS, et al. Catastrophization, fear of movement, anxiety, and depression are associated with persistent, severe low back pain and disability. The Spine Journal 20 (2020) 857−865. https://doi.org/10.1016/j.spinee.2020.02.002
- Reme SE, Ljosaa TM, Stubhaug A, et al. Perceived Injustice in Patients With Chronic Pain: Prevalence, Relevance, and Associations With Long-Term Recovery and Deterioration. The Journal of Pain 2022; 23, (7): 1196−1207 https://doi.org/10.1016/j.jpain.2022.01.007Schneider A. Donnachie E, Zipfel S, Enck P. Patients With Somatoform Disorders Are Prone to Expensive and Potentially Harmful Medical Procedures—Results of a Retrospective Cohort Study Over 15 Years. Dtsch Arztebl Int 2021;118(25):425-431. doi: 10.3238/arztebl.m2021.0135.
- Sabo MT, Roy M. Surgeon identification of pain catastrophizing versus the Pain Catastrophizing Scale in orthopedic patients after routine surgical consultation. Can J Surg, 2019; Vol. 62, No. 4, 266-269. DOI: 10.1503/cjs.009918
- Sahin N, Oztürk A, Ozkan Y, et al. What do patients recall from informed consent given before orthopedic surgery? Acta Orthop

Traumatol Turc 2010;44(6):469-75. doi: 10.3944/AOTT.2010.2396.

- Scott W, Trost Z, Milioto M, Sullivan MJL. Barriers to Change in Depressive Symptoms After Multidisciplinary Rehabilitation for Whiplash: The Role of Perceived Injustice. The Clinical Journal of Pain 2015; 31 (2): 145-151. 2015. DOI: 10.1097/AJP.0000000000000095
- Serrano-Garcia A, Fernandez-Gonzalez M, Betegon-Nicolas J, et al. Evaluation of Dram Score as a Predictor of Poor Postoperative Outcome in Spine Surgery. Journal of Clinical Medicine 2020; 9: 3825. doi:10.3390/jcm9123825
- Sherlock A, Brownie S. Patients' recollection and understanding of informed consent: a literature review. ANZ J Surg 2014 Apr;84(4):207-10. doi: 10.1111/ans.12555.
- Shlobin NA, Sheldon M, Las S. Informed consent in neurosurgery: A systematic review. Neurosurg Focus. 2020 Nov;49(5):E6. doi: 10.3171/2020.8.FOCUS20611.
- Sorel JC, Veltman ES, Honig A, et al. The influence of preoperative psychological distress on pain and function after total knee arthroplasty: a systematic review and meta-analysis. Bone Joint J 2019 Jan;101-B(1):7-14. doi: 10.1302/0301-620X.101B1.BJJ-2018-0672.R1.
- Springborg AH, Visby L, Kehlet H, et al. Psychological predictors of acute postoperative pain after total knee and hip arthroplasty: A systematic review. Acta Anaesthesiol Scand. 2023;67:1322–1337. DOI: 10.1111/aas.14301
- Strøm J, Bjerrum MB, Nielsen CV, et al. Anxiety and depression in spine surgery—a systematic integrative review. The Spine Journal 2018; 18: 1272–1285. https://doi.org/10.1016/j.spinee.2018.03.017
- Sullivan MJL, Bishop SR. The Pain Catastrophizing Scale: Development and Validation. Psychological Assessment 1995; 7 (4): 524-532.
- Sullivan MJL, Adams H, Horan S, et al. The role of perceived injustice in the experience of chronic pain and disability: scale

development and validation. J Occup Rehabil 2008; 18 (3): 249-61. doi: 10.1007/s10926-008-9140-5.

- Suri P, Pearson AM, Shao W, et al. Pain Recurrence after Discectomy for symptomatic Lumbar Disc Herniation. Spine 2017; 42 (10): 755-763. DOI: 10.1097/BRS.0000000000001894
- Vajapey SP, Cvetanovich GL, Bishop JY, Neviaser AS. Psychosocial factors affecting outcomes after shoulder arthroplasty: a systematic review 2020; 29 (5): E175-E184. https://doi.org/10.1016/j.jse.2019.09.043
- Vargas-Prada S, Coggon D. Psychological and psychosocial determinants of musculoskeletal pain and associated disability. Best Pract Res Clin Rheumatol 2015; 29 (3): 374-390. doi:10.1016/j.berh.2015.03.003.
- Vranceanu AM, Barsky, A, Ring D. Current Concepts Review: Psychosocial Aspects of Disabling Musculoskeletal Pain. J Bone Joint Surg Am. 2009; 91: 2014-8. doi:10.2106/JBJS.H.01512
- Vranceanu AM, Bachoura A, Weening A, et al. Psychological Factors Predict Disability and Pain Intensity After Skeletal Trauma. J Bone Joint Surg Am. 2014; 96:e20(1-6). http://dx.doi.org/10.2106/JBJS.L.00479

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Dr. J. Wills Oglesby was appointed Assistant Medical Director for the Bureau of Workers' Compensation in the Summer of 2021. He graduated from the University of Tennessee School of Medicine in Memphis in 1978. His orthopedic residency was served at the University of North Carolina at Chapel Hill. He completed his training as chief resident of that program in 1983. He practiced as an orthopedic surgeon at TOA for the next 38 years, until his retirement in 2021. Dr. Oglesby is certified by the American Board of Orthopaedic Surgery.

Dr. Robert Snyder was appointed Medical Director for the Bureau of Workers' Compensation in January, 2014 after 37 years of private practice in Orthopaedics. He graduated from Wayne State University School of Medicine in Detroit and completed two years of general surgery training at the University of Pittsburgh before he came to Nashville, completing his residency in Orthopaedics and Rehabilitation at Vanderbilt University.

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Jay Blaisdell, MPA, is the coordinator for the Tennessee Bureau of Workers' Compensation's MIR and CPP Registries. He has been the managing editor of AdMIRable Review since 2012. He is certified in public policy and medical impairment rating methodology. He earned a master's degree in humanities from California State University, Carson, and a master's degree in public administration from Tennessee State University in Nashville.

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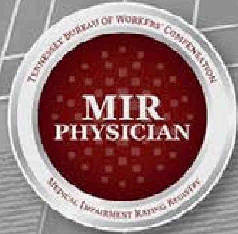

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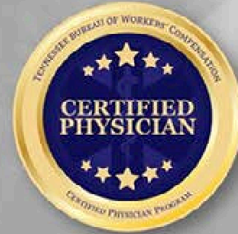

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