



## IMED, INC.

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Case No.:

### IRO REVIEWER REPORT

**DATE OF REVIEW:** 04/06/07

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Items in Dispute: Individual counseling x four (4) sessions.

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

Clinical Psychologist  
TSBEP Credentialed Health Service Provider Since 1997  
Faculty Member for Designated Doctor Training Courses (1996-2003)

**REVIEW OUTCOME:**

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

Overtured

Individual counseling x four (4) sessions is approved.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. Employer's First Report of Injury or Illness.
2. 07/17/03 – Chest one view x-ray by M.D.
3. 07/19/03 –Rehab Center physical therapy initial evaluation.
4. 01/07/04 –M.D.
5. 01/12/04 – Lumbar assessment.
6. 02/24/04 – Right knee two views.
7. 03/05/04 – New patient consultation, M.D.

8. 04/02/04 –M.D.
9. 04/30/04 –M.D.
10. 05/18/04 – Review of cervical MRI by M.D.
11. 05/28/04 – M.D.
12. 06/30/04 – Initial comprehensive evaluation note, M.D.
13. 07/21/04 – CT scan of the lumbar spine without enhancement by M.D.
14. 08/18/04 – Follow-up notes, M.D.
15. 09/20/04 – Follow-up notes, M.D.
16. 10/11/04 – Follow-up notes, M.D.
17. 11/11/04 – Follow-up notes, M.D.
18. 11/16/04 – Neurosurgical follow-up, M.D.
19. 11/19/04 – Follow-up notes, M.D.
20. 11/14/04 – Maximum Medical Improvement & impairment rating evaluation, M.D.
21. 12/10/04 – Follow-up notes, M.D.
22. 01/07/05 – Follow-up notes, M.D.
23. 04/18/05 – Follow-up notes, M.D.
24. 05/16/05 – Follow-up notes, M.D.
25. 05/17/05 –M.D.
26. 06/14/05 – Neurosurgical follow-up by M.D.
27. 06/14/05 – Neurosurgical follow-up & addendum by M.D.
28. 06/27/05 – Initial comprehensive evaluation note, LMSW.
29. 07/29/05 – M.D.
30. 09/16/05 –M.D.
31. 09/16/05 – Functional Capacity Evaluation.
32. 10/05/05 – Neurosurgical follow-up, M.D.
33. 10/19/05 – CT of the lumbar spine.
34. 11/10/05 –M.D.
35. 05/16/06 – Peer review, M.D.
36. 05/19/06 –Healthcare Systems, diagnostic interview & treatment plan by LPC.
37. 05/19/06 – Functional Capacity Evaluation.
38. 05/22/06 – Rebuttal letter from M.D.
39. 06/22/06 – M.D.
40. 06/28/06 –M.D.
41. 06/29/06 – Return to work evaluation, M.D.
42. 09/08/06 – Two view thoracic spine by M.D.
43. 09/08/06 – Three view lumbar spine by M.D.
44. 09/13/06 – M.D.
45. 10/25/06 – M.D.
46. 10/26/06 – Treatment update, LCSW.
47. 11/02/06 – Return to work evaluation, M.D.
48. 12/13/06 – M.D.
49. 12/19/06 –Healthcare Systems.
50. 01/16/07 –Healthcare Systems.
51. 02/27/07 – Independent Medical Evaluation by M.D.

**INJURED EMPLOYEE CLINICAL HISTORY (SUMMARY):**

The employee was injured while working as a nurse. She lifted a patient's leg and sustained a back injury. She had three back surgeries beginning with a T11-S1 fusion in July, 2000. She

had a refusion of L5-S1 in 2002 and the same level again in July, 2003. The employee has been disabled since 1999 and receives disability benefits. She received a 23% impairment rating. The employee reported she was told she died during one surgery and was revived. There has been reduced pain after each surgery which then returns. She has also received physical therapy and injections. She has been maintained on various medications over the last several years, most consistently pain medication and neuropathic pain medications. At times she has been on antidepressants, but not currently according to the records. The employee has significant other medical conditions including a history of TIAs, bilateral carpal tunnel releases, cancer in remission, hernia repair in 2000, diabetes, high blood pressure, and obesity. The employee had banding surgery in 1995 and stomach bypass in 2004, but reportedly remained significantly overweight.

There are references to “chronic depression” in the records of Dr. in 2004 and also by Dr. in 2005. In 2004, Dr. recommended a spinal cord stimulator, which led to a presurgical mental health evaluation. This was performed in January, 2005 by LMSW. Her review of the records indicated that the employee had a prior psychological evaluation and two or three individual psychotherapy sessions after each surgery. There was no documentation depression existed prior to the date of injury, and she was described as active. At the time of the 2005 mental health evaluation, the employee presented with moderate depression and anxiety. The P-3 psychological screening test showed depression and somatization above average as compared to other pain patients, with average anxiety. The diagnosis at that time was major depressive disorder single episode moderate, generalized anxiety disorder, and pain disorder associated with psychological factors and a general medical condition. Because of the psychological issues, the recommendation was that the employee receive psychotherapy and behavioral pain management training prior to undergoing a spinal cord stimulator trial. Based on this, the employee was then referred to a comprehensive pain management program. There were repeated references to the referral, but it does not appear she was evaluated for such a program until May, 2006.

The employee was seen at Health Care Systems for a diagnostic interview on 05/19/06. Records indicate that the employee was seen by a psychiatrist for four visits in 2002 for individual therapy and medication management. She was on no psychiatric medication at the of the May 2006 evaluation. She complained of pain of 5-8/10. Depression and anxiety were both in minimal range with BDI of 9 and BAI of 7. She had never received any behavioral pain management training. The only diagnosis at that time was pain disorder associated with psychological factors and a general medical condition. They recommended a full twenty day comprehensive pain management program. Apparently this was not authorized, but the reason was not contained in the records. Apparently she was significantly physically disabled and was not even able to perform any lifting during the physical examination.

There was an “update” form from Health Care Systems from October, 2006. At that time, the employee’s depression and anxiety were in the mild range with Beck depression and anxiety scores of 17 and 13 respectively. Apparently this led to a request for four sessions of individual counseling. This was apparently not authorized, and there a letter requesting appeal dated 01/16/07 from Health Care Systems. They reviewed the change in her symptoms and recommended a course of individual psychotherapy. This was to include cognitive behavioral techniques for depression and anxiety, as well as to teach coping strategies for managing her pain. They respond to the rationale in the denial that unimodal therapy is not supported for pain relief, but they indicated they were providing this as an initial introduction to pain management training in a less intense setting and a more conservative manner. Goals did include increasing

her active role in her recovery and improving her daily activity levels. This request for appeal was also non-authorized. The main rationale appeared to be concern that providing such treatment would “reinforce disability mindset” in part due to the plan lacking a combination of psychological and physical techniques to increase activity level while reducing fear of activity.

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

Based upon a complete review of the available records and appropriate evidence-based guidelines, it is recommend that the previous non-authorization of four sessions of individual psychotherapy be overturned. Records reflect a mild to moderate degree of depression and anxiety, for which cognitive behavioral psychotherapy is an evidence-based treatment approach. This is referenced in *Official Disability Guidelines, Mental Disorder Chapter* : “Cognitive Therapy for Depression: Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). ([Paykel, 2006](#)) ([Bockting, 2006](#)) ([DeRubeis, 1999](#)) ([Goldapple, 2004](#)) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. ([Gloaguen, 1998](#)) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. ([Thase, 1997](#)) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. ([Corey-Lisle, 2004](#)) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. ([Pampallona, 2004](#)) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy.” *Practice Guidelines for the Treatment of Patients With Major Depressive Disorder, Second Edition, American Psychiatric Association*, also supports the use of cognitive-behavioral psychotherapy for depression, with either psychotherapy or medications indicated for mild to moderate depression.

Regarding cognitive behavioral treatment for chronic pain, this is also supported by evidence-based guidelines. This includes the *Official Disability Guidelines, ODG Pain Chapter*: “Psychological treatment. Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient’s pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following “stepped-care” approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.

Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach.”

Specific coping skills training for chronic pain and delayed recovery is also reference a *ACOEM Chapters 5 and 6*. ACOEM Chapter 5, page 91: “A number of techniques are available to teach coping skills, depending on the patient’s specific needs and skill deficits. Referral to a behavioral health professional trained in these areas may a very important investment in the patient’s overall outcome.” ACOEM Chapter 6, page 116: “Pain that persists or does not completely resolve may challenge a patient’s coping skills. The appropriate treatment may be reinforcement of coping skills rather than attempts to suppress a self-perpetuating pain cycle with medication or surgery.”

While this individual level therapy is not a substitute for a multidisciplinary chronic pain program for those are in need of one, individual level cognitive behavioral therapy services for pain, anxiety, and depression are supported by evidence-based guidelines and other literature. They also provide a “lower level” or less intensive introduction to cognitive behavioral techniques often recommended prior to participation in a full chronic pain management program.

If the IMED’s decision is contrary to: (1) the DWC’s policies or guidelines adopted under Labor Code §413.011, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of non-network health care or (2) the networks treatment guidelines, IMED must indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care.

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

- A. *Official Disability Guidelines*
- B. *Practice Guidelines for the Treatment of Patients With Major Depressive Disorder, Second Edition, American Psychiatric Association*
- C. *ACOEM Guidelines*