

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** DECEMBER 5, 2007

**IRO CASE #:**

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

Medical necessity of proposed 8 sessions of individual psychotherapy (90806)

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

This case was reviewed by a clinician with a Ph.D. in clinical Psychology and who is licensed in the State of Texas. The reviewer specializes in general psychology and behavioral pain management and is engaged in full time practice.

### **REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- XX Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.80	90806		Prosp	6					Overtured
722.80	90806		Prosp	2					Upheld

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

TDI-HWCN-Request for an IRO-21 pages, ODG guidelines referenced in Medical Business Management letter 10.29.07

Respondent records- a total of 71 pages of records received by Evaluation to include but not limited to: notes, Evaluation, 12.20.04-12.22.04; various DWC 69, 32 forms; notes, 2.12.04-

12.3.04; Associates x-ray report, 12.12.04, 6.17.04; MRI L-Spine 3.4.04, 11.11.04; NCV study 3.12.04; notes, Dr., 6.4.04-10.14.04; notes, Dr., 8.3.04; notes, Dr. 9.10.04; letter 12.7.04; dos 12.22.04

Requestor records- a total of 24 pages of records received to include but not limited to: notes, 11.16.07; note, Dr. 10.2.07; notes, 8.10.07; DWC 73 form; 8.10.07; report, Dr. 7.25.07; MRI L-Spine 7.20.07; note Dr, 6.27.06

Treating Doctor records- a total of 11 pages of records received by Dr. I to include but not limited to: TDI Notice of Assignment; notes, Dr. I, 4.6.06-6.27.06; NCV study 6.13.06; MRI L-Spine 5.12.06

Treating Doctor records- a total of 71 pages of records received by Dr. to include but not limited to: notes, Dr. 4.2.04-12.2.04; MRI L-spine 11.11.04, 3.4.04; report, 8.18.04-8.19.04; labs 9.11.04; Associates report, 2.12.04; NCV study 3.12.04; notes 2.12.04-3.9.04; DWC forms 73; 2.12.04

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant is a xx year old male who was injured at work on xx/xx/xx while performing his job duties as a . Patient injured his low back when he became involved in a fight at school. Records indicate he has since received the following diagnostics/interventions: x-rays and MRI's, physical therapy, surgery, and spinal cord stimulator. Patient's diagnoses are: L4-L5 herniated disk, L5 radiculopathy, lumbosacral contusion, cervical strain, and lumbar/thoracic radiculitis. On August 18, 2004, patient underwent laminectomy and discectomy at L4-L5. Repeat MRI done on July 25, 2007 showed mild disc protrusion and spondylosis at L4-L5 and EMG/NCS showed L5 radiculopathy at L5. Current medications are Naproxen and Vicoden.

Patient's current complaints include mild (BDI = 14) symptoms of depression and moderate (BAI = 22) anxiety typified by worry about falling at school due to inability to stand and keep his balance, feeling overwhelmed, burning pain in his feet and legs (average VAS = 6/10), decreased ADL's, rectal incontinence, difficulty performing his job duties, and embarrassment. Patient is reported to have had none of these types of problems, a clean work history, and no previous need for therapy prior to the injury. Patient was currently diagnosed with 307.89 Pain disorder with both psychological factors and a general medical condition.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

The requested services are considered reasonable for this patient and medically necessary, especially with regard to increasing the claimant's ability to stay at work. ODG and TDI both support early identification of roadblocks to recovery, and some form of minimal intervention in the early stages of treatment using a stepped-care approach. Claimant appears to genuinely be suffering psychological sequelae of his work-related injury, and is displaying current reduced ability to function. His primary coping mechanism at this time appears to be medications, and these need to be supplanted with more active coping strategies on the patient's part. As such, the current request for 1x6 individual therapy sessions seems reasonable and is the appropriate step to intervene with at this point. See ODG Stress, Pain, and Low Back chapters:

Delay of Treatment: Not recommended. Delayed treatment tends to increase costs, and prompt and appropriate medical care can control claims costs. One large study found that "adverse surprises," meaning cases that ended up costing far more than initially expected, were caused when the initial treatment came late in the cases, and these cases can account for as much as 57 percent of total costs. These surprise cases tended to involve back pain. (WCRI, 2005) (Joling,

2006) (PERI, 2005) (Smith, 2001) (Stover, 2007) Delayed recovery has been associated with delayed referral to nurse case management. (Pransky, 2006)

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) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (Royal Australian, 2003) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (Warren, 2005)

**ODG Psychotherapy Guidelines:**

Initial trial of 6 visits over 6 weeks

With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Per ODG: 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. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines for low back problems. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005)

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

XX PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (SEE ABOVE  
REFERNCES IN RATIONALE)