

True Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 214-276-1904

IRO REVIEWER REPORT TEMPLATE -WC

DATE OF REVIEW: 12/03/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Original Request: Individual psychotherapy 1X8; Relaxation Therapy 1x8

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

Clinical psychologist; Member American Academy of Pain Management; Member Certified Accreditation of Pain Management

REVIEW OUTCOME

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

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

1 X 6 sessions of individual therapy is medically necessary.

The original request of 1 X 8 sessions of individual therapy and 1 X 8 sessions of relaxation therapy were reduced to 1 X 6 sessions of individual therapy which is considered medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

NoODG Guidelines

09-12-07 Initial assessment and evaluation; LPC
09-20-07 First denial letter; PsyD
undated Letter of Appeal; LPC
10-03-07 Second denial letter; PhD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured at work on xx/xx/xx while performing her job duties as an xx. Patient reports injuring her low back when she attempted to lift a heavy file box weighing approximately 45 pounds. She was taken by ambulance to the ER, treated, and released the same day. She has since been given appropriate diagnostics to include x-ray, MRI, EMG, and a bone density test. Results of these tests are not given, and only the diagnostic codes of 724.1, 724.9, and 720.2 are listed. Patient has been treated conservatively with active and passive therapies, injections, and medications to include Soma, Motrin, Elavil, and Valium.

Patient's current complaints include moderate symptoms of depression and anxiety typified by worry about re-injury, feeling overwhelmed, being less involved with family, sleep disturbance, irritability, weight loss (30 pounds) and marital problems. 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 reports her current pain level at a 6/10, and average pain level at a 5/10. Functioning is impacted in the areas of household tasks, social activities, hobbies, home maintenance, travel, and yard work, and work in general.

Patient was diagnosed with adjustment disorder with mixed anxiety and depressed mood, and pain disorder associated with both psychological factors and a general medical condition. Current GAF is 58 and pre-injury GAF is 93. The original request for 1x8 individual therapy sessions and 1x8 relaxation sessions was modified with the appeal letter to 1x6 individual therapy sessions. The goals for these sessions would include: decreasing the patient's perception of disability, mood disturbance, interpersonal stressors, etc. to mild levels by employing cognitive behavioral techniques.

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

ODG and TDI both support early identification of roadblocks to recovery, and some form of minimal intervention in the early stages of treatment. (See Delay of Treatment in ODG Pain section). Patient appears to genuinely be suffering psychological sequelae of her work-related injury, her pain, and her current reduced ability to function. Her primary coping mechanism at this time appears to be medications, and these need to be supplanted with more active coping on the patient's part. As such, the current request for 1x6 individual therapy 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)

Behavioral Treatment: Recommended as option for patients with chronic low back pain and delayed recovery. Also recommended as a component of a Chronic pain program (see the [Pain Chapter](#)). Behavioral treatment, specifically cognitive behavioral therapy (CBT), may be an effective treatment for patients with chronic low back pain, but it is still unknown what type of patients benefit most from what type of behavioral treatment. Some studies provide evidence that intensive multidisciplinary bio-psycho-social rehabilitation with a functional restoration approach improves pain and function. (Newton-John, 1995) (Hasenbring, 1999) (van Tulder-Cochrane, 2001) (Ostelo-Cochrane, 2005) (Airaksinen, 2006) (Linton, 2006) (Kaapa, 2006) (Jellema, 2006) Recent clinical trials concluded that patients with chronic low back pain who followed cognitive intervention and exercise programs improved significantly in muscle strength compared with patients who underwent lumbar fusion or placebo. (Keller, 2004) (Storheim, 2003) (Schonstein, 2003) Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate on this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). (Lang, 2003) A recent RCT concluded that lumbar fusion failed to show any benefit over cognitive intervention and exercises, for patients with chronic low back pain after previous surgery for disc herniation. (Brox, 2006) Another trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. (The cognitive treatment focused on encouraging increased physical activity.) (Smeets, 2006) For chronic LBP, cognitive intervention may be equivalent to lumbar fusion without the potentially high surgical complication rates. (Ivar Brox-Spine, 2003) (Fairbank-BMJ, 2005) See also Multi-disciplinary pain programs in the [Pain Chapter](#).

ODG cognitive behavioral therapy (CBT) guidelines for low back problems:

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See [Fear-avoidance beliefs questionnaire](#) (FABQ).

Initial therapy for these “at risk” patients should be [physical therapy exercise](#) instruction, using a cognitive motivational approach to PT.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks

- With evidence of objective [functional improvement](#), total of up to 6-10 visits over 5-6 weeks (individual sessions)

Per ODG: Psychological Screening: Recommended as an option prior to surgery, or in cases with expectations of delayed recovery. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as MMPI (Minnesota Multiphasic Personality Inventory) and Waddell signs. ([Scalzitti, 1997](#)) ([Fritz, 2000](#)) ([Gaines, 1999](#)) ([Gatchel, 1995](#)) ([McIntosh, 2000](#)) ([Polatin, 1997](#)) ([Riley, 1995](#)) ([Block, 2001](#)) ([Airaksinen, 2006](#))

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](#))

Psychological evaluations: Recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. ([Main-BMJ, 2002](#)) ([Colorado, 2002](#)) ([Gatchel, 1995](#)) ([Gatchel, 1999](#)) ([Gatchel, 2004](#)) ([Gatchel, 2005](#))

For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. ([Gatchel, 1999](#)) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. ([Linton, 2002](#)) Other studies and reviews support these theories. ([Perez, 2001](#)) ([Pulliam, 2001](#)) ([Severeijns, 2001](#)) ([Sommer, 1998](#)) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. ([Lin-JAMA, 2003](#))

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)