

**C-IRO, Inc.**  
**An Independent Review Organization**  
7301 Ranch Rd. 620 N, Suite 155-199  
Austin, TX 78726

Notice of Independent Review Decision

**DATE OF REVIEW: 12/2/07**

**IRO CASE #:**

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

Individual psychotherapy 1X6; Biofeedback therapy 1x6

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

Clinical psychologist; Member American Association 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Psychological evaluation of 03-08-07 requesting PPA and psyc testing; LPC
- Record review of 3-29-07; MD
- IRO denial for psych testing and PPA of 4-24-07
- RME of 5-7-07; MD
- Case Conference notes of 6-4-07 requesting Work hardening; LPC
- Office notes of 5-21,6-5, 6-18, and 7-3-07; DO
- FCE report on 7-10-07; DC
- Operative report of 8-2-07 by,MD
- Office notes of 7-16, 8-1, 8-17, and 9-13-07; DC
- Exam notes of 7-27, 8-17, and 10-2-07; MD
- Behavioral Medicine Re-eval of 10-15-07; LPC

- Reconsideration request of 10-31-07; LPC
- Letters of denial; 10-18-07 by PhD and 11-06-07 by PhD
- Official Disability Guidelines

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

The claimant is a male who was injured performing his regular job duties as a . He and a co-worker were in the process of lifting stones weighing approximately 120 pounds, when he felt onset of pain in his low back. He sought immediate treatment on the date of the injury, to include x-rays. Following this, he continued to experience pain, and over the course of his therapy and treatments has received appropriate diagnostics and interventions to include: MRI, EMG, physical therapy x 9, lumbar ESI's, and ultimately surgical intervention for the diagnosed L5-S1 disk herniation with possible nerve root compression.

On 3-8-07, psychological testing and a PPA were requested, and ultimately denied through IRO process as not being medically necessary. At this evaluation, the claimant rated his pain level at 4/10 and his average daily pain level at 6/10, with intermittent elevations to 9/10. Additionally, when patient was asked to quantify certain targeted symptoms, he endorsed the following: irritability and restlessness was 7/10, vocational/financial distress was 6/10, insurance claim issues were rated 5/10, muscular tension 7/10, anxiety and worry 3/10, sleep problems 7/10, and forgetfulness/poor concentration 5/10. At this time he was diagnosed as rule out adjustment disorder with mixed anxiety and depression.

Surgery was performed on 8-2-07, and was an L5-S1 discectomy and decompression. Follow-up surgical note of 10-2-07 by the surgeon states that "the patient states he has improved subsequent to discectomy, but still has a considerable amount of left leg pain...Before stating that he is maximally improved, he requires a gadolinium enhanced lumbar MRI scan to confirm that he does not have residual or recurrent disc herniation with nerve compression.

Patient was again evaluated on 10-15-07 to request IT and biofeedback. At this evaluation, the claimant rated his pain level at 5/10 and his average daily pain level at 4-5/10, with intermittent elevations to 6/10. Additionally, when patient was asked to quantify certain targeted symptoms, he endorsed the following: irritability and restlessness was 2/10, vocational/financial distress was 5/10, insurance claim issues were rated 2/10, muscular tension 6/10, anxiety and worry 2/10, sleep problems 4/10, and forgetfulness/poor concentration 1/10. At this time he was diagnosed as major depressive disorder, moderate. It was noted in the report that the patient was referred by his treating doctor per a script of 10/1/07 because he "was experiencing trouble adjusting to his post operative recovery, had increased pain complaints, and mood disturbance."

However, follow-up office note by the treating doctor on 9-13-07 stated that patient "has decreased pain at the lumbar spine due to the surgery. He has increased ROM over the past 2 weeks. He still shows neurological deficits at the

left on muscle testing but appears to be gaining strength. He has relatively normal muscle tone. Muscle spasms within the lumbar paraspinal muscles are guarded.”

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

Patient was denied for PPA via IRO on 4/24/07. The reviewer stated that “the biofeedback PPA assessment is not reasonable or necessary...Inasmuch as biofeedback is not indicated or reasonable for the employee’s condition, there is no basis for obtaining a biofeedback study, which is the purpose of a PPA.” ODG has been adopted by TDI as the evidence-based standard on which all requests for services are evaluated. ODG guidelines state that biofeedback is “not recommended, since it has not been shown to be superior to basic behavioral relaxation techniques.” As such, this reviewer finds the current request for biofeedback is not medically necessary.

ODG recommends cognitive-behavioral therapy for depression, stating that “the gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy.” However, in this case, the given diagnosis of MDD appears to be incorrect. The clinical course for the patient shows significant improvement across all assessed measures over time and, in particular, after the surgical intervention. It is furthermore difficult to understand how an initial diagnosis of adjustment disorder is subsequently upgraded to MDD, even though all symptoms are improving, and there is no indication that this progress will not continue.

In addition, the ODG TWC stress chapter states that initial evaluation should “focus on identifying possible red flags or warning signs for potentially serious psychopathology that would require immediate specialty referral. Red flags may include impairment of mental functions, overwhelming symptoms, signs of substance abuse, or debilitating depression. In the absence of red flags, the occupational or primary care physician can handle most common stress-related conditions safely”. The determination that medical necessity could not be established at this time is upheld. (*See the following from ODG Work Loss Data, 2007*):

**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](#)) 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)

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

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs.

Initial therapy for the “at risk” patients should be by 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)

**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. 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:**

- 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)