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DATE OF REVIEW: JUNE 29, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual counseling 1 time per week x 4 weeks (4 sessions)

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

Board certified in Occupational Medicine, licensed in the State of Texas, and DWC ADL approved.

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)

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Individual counseling 1 time per week x 4 weeks (4 sessions)	90806	Upon approval	Adverse determination upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Record Description	Record Date
Diagnostic Interview and treatment plan –- Bexar	08/03/06
Preauthorization request 4 sessions Individual counseling –LCSW	04/03/07
Non-authorization of preauthorization request –	04/09/07
Appeal letter to non-authorization –- Bexar	04/25/07
Non-authorization of appeal -	05/04/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an injury to the shoulder and back.

There is a request for individual psychotherapy 4 visits. This was declined at preauthorization and at appeal as well. Report of 8/3/06 indicates that the patient had lumbar surgery on 2002 which was of no help. She has had formal PT and a work hardening program post-op. The patient is on SS disability and has not worked since 2001. She does not have a job to return to and does not know what kind of work she would be capable of doing. Patient reports ongoing LBP 100% of the time with most regular activities walking,

standing, sitting and with performance of ADLs and household chores. Patient score in the moderate to severe in the Beck Depression and Anxiety Inventories. Patient diagnosed with chronic pain syndrome and felt to benefit from a CPMP. Planned intervention modalities included supportive and cognitive behavioral psychotherapy. Report of 4/3/07 Request for individual psychotherapy.

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

The patient appears to have attended both WH and CPMP of 10 visits. These are more aggressive forms of medical interventions for deemed psychological problems than the requested 4 visits to individual psychotherapy. If the patient did not obtain substantial benefit from a multidisciplinary program such as WH and a CPMP, there is little reasonable likelihood of success from 4 visits to individual psychotherapy.

Lastly it is not stated as to what the purpose of the individual psychotherapy. This is an individual who appears to have high levels of perceived pain but apparently not taking narcotics on any regular basis. She is on SS disability and from interview of 8/3/06 has little interest in RTW based on the fact that she is not certain what type of work she would like to do and is not actively looking for employment. The chances of a claimant who has not worked since 2001 and on SS disability to RTW in any capacity are remote at best. There are no clear goals as to what the individual psychotherapy seeks to accomplish and to what end. Simply performing a few visits to obtain lower BAI and BDI scores and declaring victory is hardly a reason to perform the requested intervention and would not likely benefit the claimant in any way that would change her current situation either objectively or subjectively. Patient is not exhibiting motivational change - see #5 in the above citation.

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

ODG - TWC Pain Procedure summary

Recommended where there is access to programs with proven successful outcomes. Also called Multidisciplinary pain programs or Interdisciplinary rehabilitation programs, these pain rehabilitation programs combine multiple treatments, and at the least, include psychological care along with physical therapy. While recommended, the research remains ongoing as to (1) what is considered the "gold-standard" content for treatment; (2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) Unfortunately, being a claimant may be a predictor of poor long-term outcomes. (Robinson, 2004) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003)

Types of programs: There is no one universal definition of what comprises interdisciplinary/multidisciplinary treatment. The most commonly referenced programs have been defined in the following general ways (Stanos, 2006):

(1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:

(a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)

(b) Multidisciplinary pain clinics

(c) Pain clinics

(d) Modality-oriented clinics

(2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs.

Types of treatment: Components suggested for interdisciplinary care include the following services delivered in an integrated fashion: (a) physical therapy (and possibly chiropractic); (b) medical care and supervision; (c) psychological and behavioral care; (d) psychosocial care; (e) vocational rehabilitation and training; and (f) education.

Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. (Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel2, 2005) See also Chronic pain programs, early intervention; Chronic pain programs, intensity; Chronic pain programs, opioids; and Functional restoration programs.

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

(1) An adequate and thorough evaluation has been made.

(2) Previous methods of treating the chronic pain have been unsuccessful.

(3) The patient has a significant loss of ability to function independently resulting from the chronic pain.

(3) The patient is not a candidate where surgery would clearly be warranted.

(5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change.

Integrative summary reports that include treatment goals, progress assessment and stage of treatment, must be made available upon request and at least on a bi-weekly basis during the course of the treatment program. Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains.

Inpatient admissions for pain rehabilitation may be considered medically necessary only if there are significant medical complications meeting medical necessity criteria for acute inpatient hospitalization.

(BlueCross BlueShield, 2004) (Aetna, 2006) See Functional restoration programs.