



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 10/17/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy once a week for six weeks

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

Board Certified in Psychology

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Individual psychotherapy once a week for six weeks - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by D.C. dated 02/05/07
A lower extremity EMG/NCV study interpreted by Sr., M.D. dated 04/30/07
An evaluation with D.O. dated 06/04/07
A procedure note from Dr. dated 06/08/07
A prescription from D.C. dated 06/21/07
A behavioral medicine evaluation with Ph.D. dated 07/03/07
A preauthorization request from Dr. dated 08/09/07
An environmental intervention with Dr. dated 08/13/07
Letters of denial, according to the ODG, from, R.N. dated 08/15/07 and 09/06/07
A reconsideration request from L.P.C. dated 08/28/07

PATIENT CLINICAL HISTORY

An MRI of the lumbar spine interpreted by Dr. on 02/05/07 revealed a disc protrusion at L5-S1 and facet synovitis at L1-L2, L2-L3, and L4-L5. An EMG/NCV study interpreted by Dr. on 04/30/07 revealed bilateral peroneal, tibial motor and sural sensory neuropathy and axonal type neuropathy or bilateral SI radiculopathy could not be completely ruled out. On 06/04/07, Dr. recommended lumbar epidural steroid injections (ESIs). On 06/08/07, Dr. performed a lumbar ESI at L5-S1. On 06/21/07, Dr. recommended individual counseling. On 07/03/07 and 08/09/07, Dr. recommended six sessions of individual therapy. On 08/15/07 and 09/06/07, Ms. wrote letters of adverse determination for the individual therapy. On 08/28/07, Ms. wrote a reconsideration request for the individual therapy.

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

Despite an apparent presurgical psychological evaluation that did not suggest a psychological diagnosis, the evaluation reviewed here provides a thorough evaluation, adequate documentation, and objective testing to establish the diagnosis of Adjustment Disorder with Mixed Anxiety and Depressed Mood secondary to patient's work related injury. The treatment goals were clearly spelled out for the six requested treatment sessions. The documentation suggested that the patient did not require psychological evaluation or treatment prior to his injury. He was coping well and managing several jobs effectively before his injury.

Therefore, the requested individual psychotherapy once a week for six weeks is reasonable and necessary as related to the original injury.

ODG 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 anti-depressant medication with severely depressed outpatients in four major comparisons.

Effects may be longer lasting (80% relapse rate with anti-depressants versus 25% with psychotherapy). (Paykel, 2006) (Bocking, 2006) (DeRubeis, 1999), (Goldapple, 2004). It also fared well in a meta-analysis comparing 78 clinical trials from 1977-1996. (Gloaguen, 1998).

ODG Psychotherapy Guidelines:

Initial trial of six visits over six 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 patients with risk factors for delayed recovery, including fear avoidance beliefs.

Initial therapy for these “at risk” patients should be physical therapy exercise instruction, using a cognitive motivational approach to physical therapy.

Consider separate psychotherapy CBT referral after four weeks if lack of progress from physical therapy alone:

Initial trial of three psychotherapy visits over three weeks

With evidence of objective functional improvement, total of up to five to six visits over five to six weeks (individual sessions).

ODG Recommended. Mind/body intervention programs have been shown to reduce perceived stress and anxiety. One clinical trial on college students tested the effect of a mind/body intervention (consisting of six 90-minute group-training sessions in relaxation response and cognitive behavioral skills) to reduce stress and found that significantly greater reductions in psychological distress, anxiety, and perceived stress were found in experimental group. (Deckro, 2002).

Cognitive therapy for general stress: ODG Recommended. Stress management that includes cognitive therapy has the potential to prevent depression and improve psychological and physiological symptoms. As with all therapies, an initial trial may be warranted, with continuation only while results are positive. (Mino, 2006) (Granath, 2006) (Siversten, 2006).

Studies show that stress inoculation training is an effective means for reducing performance anxiety, reducing state anxiety, and enhancing performance under stress. (Saunders, 1996).

Cognitive Therapy is recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain included 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 behaviors

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 is “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 appropriate. 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).

Behavioral treatment. ODG Recommended. Behavioral treatment 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 two 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 low back pain, 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.

Initial therapy for these “at risk” patients should be physical therapy exercise instruction, using a cognitive motivational approach to physical therapy.

Consider separate psychotherapy CBT referral after four weeks if lack of progress from physical therapy alone:

-Initial trial of three to four psychotherapy visits over two weeks

-With evidence of objective functional improvement, total of up to six to ten visits over five to six weeks (individual sessions).

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 AND KNOWLEDGE BASE
- 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)

X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Paykel, 2006, Bocking, 2006, DeRubeis, 1999, Goldapple, 2004, Gloaguen, 1998

Deckro, 2002

Mino, 2006, Granath, 2006, Siversten, 2006, Saunders, 1996

Otis, 2006, Townsend, 2006, Kerns, 2005, Flor, 1992, Morley, 1999, Ostelo, 2005

Newton-John, 1995, Hasenbring, 1999, van Tulder-Cochrane, 2001, Ostelo-Cochrane, 2005, Airaksinen, 2006, Linton, 2006, Kaapa, 2006, Jellema, 2006

Keller, 2004, Storheim, 2003, Schonstein, 2003

Lang, 2003

Brox, 2006

Smeets, 2006

Ivar Brox-Spine, 2003, Fairbank-BMJ, 2005