

RYCO MedReview

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 Employer's First Report of Injury or Illness form dated xx/xx/xx

An Associate Statement from the patient dated xx/xx/xx

Return to work/school notes from various providers (the signatures were illegible) dated xx/xx/xx and 08/10/06

An evaluation with, M.D. dated 08/15/06

DWC-73 forms from Dr. dated 08/15/06, 08/28/06, and 09/05/06

An evaluation with, P.T. dated 08/17/06

Evaluations with, M.D. dated 08/18/06, 08/28/06, and 09/05/06

X-rays of the orbits interpreted by, M.D. dated 08/24/06

An MRI of the cervical spine interpreted by, M.D. dated 08/24/06

A physical therapy progress note from Ms. dated 08/24/06

A physician activity status report from Dr. dated 08/28/06

Evaluations with, D.C. dated 09/13/06, 02/13/07, and 02/14/07

DWC-73 forms from Dr. dated 09/13/06, 10/13/06, 05/11/07, and 05/23/07

Chiropractic therapy with Dr. dated 09/13/06, 12/05/06, 12/06/06, 12/07/06, 12/12/06, 12/13/06, 12/14/06, 12/18/06, 12/29/06, 01/23/07, 01/26/07, 01/30/07, 02/01/07, 04/27/07, 05/04/07, and 05/11/07

A CT scan of the head interpreted by, M.D. dated 09/19/06

PLN-11 forms from the insurance carrier dated 09/19/06, 01/24/07, and 06/08/07
Functional Capacity Evaluations (FCEs) with Dr. dated 09/26/06, 11/13/06, 01/12/07, 03/06/07, 04/10/07, and 05/17/07

Evaluations with, M.D. dated 09/28/06, 10/02/06, 10/26/06, 11/09/06, 11/13/06, 12/20/06, 01/18/07, 02/14/07, 02/22/07, and 05/22/07

Chiropractic therapy with, D.C. dated 10/26/06, 10/27/06, 10/31/06, 11/02/06, and 11/03/06

Video surveillance from dated 11/03/06 and 11/04/06

A behavioral medicine evaluation with, M.Ed., L.P.C. dated 11/07/06

A Decision and Order form from, Hearing Officer at TDI-DWC, dated 11/16/06

An EMG/NCV study interpreted by, M.D. dated 12/11/06

Individual psychotherapy with Ms. dated 01/09/07

Work hardening group therapy notes from Ms. dated 02/12/07 and 02/13/07

An evaluation with an unknown nurse (signature was illegible) dated 06/08/07

An emergency room visit with an unknown provider (signature was illegible) dated 06/08/07

A CT scan of the head interpreted by an unknown provider (signature was illegible) dated 06/08/07

An MRI of the left shoulder interpreted by Dr. dated 06/19/07

Evaluations with, D.O. dated 08/01/07, 08/15/07, 08/25/07, and 09/08/07

A DWC-73 form from Dr. dated 08/01/07

An EMG/NCV study interpreted by, M.D. dated 08/15/07

A physical therapy evaluation with, P.T. dated 08/20/07

A prescription from Dr. dated 08/22/07

A behavioral medicine evaluation with, M.Ed., L.P.C. dated 08/24/07

Preauthorization requests from, Ph.D. dated 08/31/07 and 09/11/07

A letter of adverse determination, according to the ODG, from, Ph.D. at dated 09/06/07

A reconsideration request from, M.S., L.P.C. dated 09/11/07

A letter of adverse determination, according to unknown sources, from, M.D. at dated 09/18/07

A Designated Doctor Evaluation with, M.D. dated 09/28/07

An IRO Summary dated 09/29/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 08/15/06, Dr. recommended Soma, Celebrex, physical therapy, and off work status. An MRI of the cervical spine interpreted by Dr. on 08/24/06 revealed small disc bulges at C4-C5 and C5-C6. On 09/13/06, Dr. recommended a CT scan of the brain. Chiropractic therapy was performed with Dr. from 09/13/06 through 05/11/07 for a total of 16 sessions. A CT scan of the brain interpreted by Dr. on 09/19/06 was essentially unremarkable. A PLN-11 form from the insurance carrier on 09/19/06 disputed the entitlement of TIBs and disability.

Chiropractic therapy was performed with Dr. from 10/26/06 through 11/03/06 for a total of five sessions. Video surveillance from Mr. on 11/03/06 and 11/04/06 indicated no activity outside the residence by the patient. On 11/07/06, Ms. recommended individual psychotherapy and biofeedback testing once a week for six weeks. An EMG/NCV study interpreted by Dr. on 12/11/06 revealed mild bilateral carpal tunnel syndrome and moderate chronic left C6 radiculopathy. Individual psychotherapy was performed with Ms. on 01/09/07. An FCE with Dr. on 01/12/07 indicated the patient functioned at the sedentary to light physical demand level. A PLN-11 form from the insurance carrier on 01/24/07 disputed the entitlement of organic affective disorder, migraines, and depression. Group psychotherapy was performed with Ms. on 02/12/07 and 02/13/07. Work hardening was performed with Dr. on 02/13/07 and 02/14/07. An FCE with Dr. on 03/06/07 indicated the patient functioned in the light physical demand level and continued work hardening was recommended. Based on an FCE with Dr. on 04/10/07, a chronic pain management program was recommended. A PLN-11 form from the insurance carrier on 06/08/07 disputed entitlement of compensability of TIBs and disability. An MRI of the left shoulder interpreted by Dr. on 06/19/07 revealed possible mild tendinosis of the supraspinatus and musculotendinous junctions. On 08/01/07, Dr. recommended an EMG/NCV study, continued medications, and Xanax. An EMG/NCV study interpreted by Dr. on 08/15/07 was unremarkable. On 08/15/07, Dr. recommended a neurosurgical evaluation, Norco, and off work status. Ms. recommended physical therapy twice a week for three weeks on 08/20/07. On 08/24/07, Ms. recommended six sessions of individual psychotherapy. On 08/31/07, Dr. wrote a letter of preauthorization for the individual psychotherapy. On 09/06/07, Dr. wrote a letter of adverse determination for the therapy. On 09/11/07, Mr. wrote a reconsideration request for the individual psychotherapy. Dr. wrote a letter of adverse determination for the psychotherapy on 09/18/07. On 09/28/07, Dr. placed the patient at Maximum Medical Improvement (MMI) as of 08/28/07 with a 5% whole person impairment rating.

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

The behavioral medicine consultation performed by, M.Ed., L.P.C. on 08/24/07 provides a thorough evaluation, adequate documentation, objective testing to establish the diagnosis of Major Depressive Disorder, single episode, moderate, secondary to the patient's work injury. The treatment goals were clearly spelled out for the requested six sessions. The documentation suggested that the patient did not require any psychological evaluation or treatment prior to her injury. She also demonstrated a stable work history before her injury.

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

Per the ODG Psychotherapy Guidelines: 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). (DeRubes, 1999), (Goldapple, 2004). An additional study found that combined therapy (anti-depressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997). A recent meta-analysis concluded that psychological treatment combined with anti-depressant therapy is associated with a higher improvement rate than drug treatment alone. The gold standard for evidence based treatment of MDD is a combination of medication (anti-depressant) and psychotherapy. 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 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.

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 Multidisciplinary 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 biopsychosocial 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 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)

DeRubes, 1999 and Goldapple, 2004

Thase, 1997

Deckro, 2002

Mino, 2006, Granath, 2006, Siversten, 2006

Saunders, 1996

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

Ostelo, 2005

Keller, 2004, Storheim, 2003, Schonstein, 2003

Lang, 2003

Brox, 2006

Smeets, 2006

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