P-IRO Inc.

An Independent Review Organization
835 E. Lamar Blvd., #394
Arlington, TX 76011
Phone: 817-274-0868
Fax: 866-328-3894

DATE OF REVIEW: 08/01/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Individual psychotherapy 1X6

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

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
OD Guidelines
Denial Letters 7/1/08 and 7/22/08
Medical Records: 4/10/08, 4/25/08, 6/6/08
Medical Records: 7/3/07 thru 7/2/08
Medical Records: 6/20/08 and 7/16/08

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who was injured at work on xx/xx/xx. At the time, she was performing her usual job duties as a . On the above mentioned date, while bending over to pick up a box, patient heard a pop in her right knee, and experienced sharp pain radiate above and below this area. She describes that

the pain began shooting throughout her right leg and her leg gave out, causing her to fall. She received x-rays and medications through the emergency room, and established treating with Dr. Patient continues to be in an off-work status.

Claimant has received the following diagnostics and treatments to date: x-rays, MRI, knee surgery x1, and medications management. Records indicate she is currently attending post-surgical physical therapy. Although the behavioral intake report lists her surgery date as 11/07, the surgeon's note states that she is S/P surgery on 4/18/08 for right knee medial meniscus tear, lateral meniscus tear, osteochondral defect, loose body, and chondromalacia patella. Surgeon's office note of 4/25/08 states that patient "has been doing physical therapy through Dr. Crockett and has been noticing an increase in ROM and decrease in pain steadily throughout PT…Right knee pain is 3/10." On 6/6/08, he recommends Orthovisc injections for her posttraumatic arthritis. She was refilled on Celebrex, and Darvocet was prescribed prn for pain.

On 06-20-08, patient was interviewed and evaluated by LPC, in order to make psychological treatment recommendations. Patient was administered the patient symptom rating scale, BDI and BAI, along with an initial interview and mental status exam. Results indicated that the patient had developed an injury-related sleep disorder. Patient currently rates her average pain level as a 4/10VAS, stating she has less involvement in family and social activities. On the PSRS, patient had no clinically significant numbers, except she rated fears regarding "vocation" at 10/10.

The current request is for individual cognitive-behavioral therapy 1x6. Goal is to decrease the patient's reported irritability from 4/10 to 2/10, help patient challenge and replace her negative cognitions, and improve sleep.

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

The goals for treatment discussed above are illogical and cannot be considered medically necessary since the patient evaluation showed no evidence of psychopathology, no decreased mental status, an no evidence of employment of "negative cognitions", and no evidence of non-compliance with doctor's medication regimen or other directives.

In addition, the ODG TWC stress chapter states that initial evaluations 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):*

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)

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)

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)

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)**