

SENT VIA EMAIL OR FAX ON  
Dec/02/2008

## True Resolutions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**  
Dec/02/2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
4 additional sessions of Individual Psychotherapy

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

Psychologist  
Diplomate in Clinical Neuropsychology  
Diplomate in Behavioral Medicine  
Diplomate in Pain Management  
Boarded: Professional Psychology/Amr Brd Prof Neuropsychology

**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 10/1/08 and 10/28/08  
Records from 6/25/08 thru 10/20/08  
MRI 3/2/07  
Record from DTI 4/30/08  
Record from Dr. 6/5/08

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant sustained a compensable work injury on xx/xx/xx while performing his duties as an xxxx at xxx. He was lifting heavy bags of xxx and felt low back pain. He has also reported radiating pain in his lower extremities. He was referred for biopsychosocial intervention adjunctive to receiving physical therapy. He has successfully completed six (6) sessions of such intervention with good results. Four (4) additional sessions were requested. However the additional sessions of individual psychotherapy requested were not medically

necessary as the claimant had made substantial recovery in the initial six sessions provided.

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

The insured was psychologically examined and diagnosed with depression and anxiety following an industrial injury to his low back. The psychological examination was conducted in a proper fashion using well recognized tests by a licensed and qualified professional recognized to perform such examinations by TDI. Six (6) sessions of individual psychotherapy were initially approved and completed with excellent results. Xxxx then submitted a request for four (4) additional psychotherapy sessions which was initially denied and upheld on reconsideration and appeal. Basically, the requested services were denied based on an analysis and conclusion that the insured had made “great progress” and his test scores indicated he did not need additional therapy

The insured made substantial progress in the initial therapy approved. His depression levels after completing the first six treatment sessions was “minimal”. His anxiety was “mild” following this initial treatment. The requested (4) four additional psychotherapy sessions were not medically necessary based on these findings. TDI has adopted ODG as providing peer-reviewed published guidelines. While imperfect, these guidelines provide clear guidance for the reviewer and Texas-based treating professional community:

Psychological treatment is 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:

**CRITERIA:** ODG: Psychological treatment is 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. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005)

Also see:

Psychological treatment is recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See the Low Back Chapter, "Behavioral treatment", and the Stress/Mental Chapter. See also Multi-disciplinary pain programs

ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain

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 for 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 week

- With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)

With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG Mental/Stress Chapter, repeated below

ODG Psychotherapy Guidelines

- Initial trial of 6 visits over 6 week

- With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Extremely severe cases of combined depression and PTSD may require more sessions if documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials. Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders. (Leichsenring, 2008)

The following pertinent references are provided for additional consideration:

- 1) Handbook of Pain Syndromes. Mahwah, NJ: Lawrence Erlbaum Publishers, 1999- pages 77-97

- 2) American College of Occupational and Environmental Medicine. Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers. Massachusetts: OEM Press, 2nd Edition, 2003

- 3) Nielson, W.R. & Weir, R. (2001). "Biopsychosocial approaches to the treatment of chronic pain." Clinical Journal of Pain, 17(4 Suppl), S114-S127

- 4) Roberts, A. H., R. A. Sternbach, et al. (1993). "Behavioral management of chronic pain and excess disability: long-term follow-up of an outpatient program." Clin J Pain 9(1): 41-8.

- 5) Flor, H., D. J. Behle, et al. (1993). "Assessment of pain-related cognitions in chronic pain patients." Behav Res Ther 31(1): 63-73

- 6) Maloney, K et al. An overview of outcomes research and measurement. J Health Care Quarterly, 1999; Nov-Dec; 21(6):4-9
- 7) Lambert MJ, editor. Bergin and Garfield's handbook of psychotherapy and behavior change. 5Th ed. John Wiley and Sons, New York. 2004
- 8) Gatchel, Robert J., Clinical Essentials of Pain Management, 2005, American Psychological Association
- 9) Turk, D.C. & Gatchel, R.J. (Eds.). Psychological Approaches to Pain Management: A Practitioner's Handbook, Second Edition. New York: Guilford Press, 2002.

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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