

# P-IRO Inc.

An Independent Review Organization

835 E. Lamar Blvd., #394

Arlington, TX 76011

Fax: 866-328-3894

Notice of Independent Review Decision

**DATE OF REVIEW:** 1/28/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Individual psychotherapy 1X4

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

Clinical psychologist; Member American Association 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**

- CMT report by Diagnostics of 6/15/07 and 9/13/07
- FCE report by Diagnostics of 7/2/07
- PPE report by Diagnostics of 10/15/07
- Psychological evaluation of 10/15/07 requesting CPMP 4 weeks; PhD
- History and Physical of 11/9/07; MD
- Office notes of 11/27/07, 12/11/07, and 1/7/08; MD
- FCE report by of 12/4/07
- attorney letter of 1/11/08

- Adverse Determinations of 11/16/06 and 12/13/07
- No ODG Guidelines

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx year old male who was injured on xx/xx/xx/ performing his regular job duties as a xxx. He was attempting to use a wrench to tighten a large pipe, when he twisted and felt onset of pain in his low back. In various reports available for review, he has been diagnosed with cervical, thoracic, and lumbar strain/sprain. He continued to experience pain, and over the course of his therapy and treatments has received appropriate diagnostics and interventions to include: MRI, chiropractic care, physical therapy, and medication management with Tramadol, which is prescribed for pain.

Office notes from Dr. from November 2007 to January 2008 show the patient to be reporting 7-8/10 pain levels, as well as problems with sustained sitting, walking, and standing tolerances. In addition, office notes reflect problems with sweeping, bending, climbing, and lifting, but no problems with psychological issues, and no psychotropic medications were prescribed. The requested FCE's show patient progressing from the light to the light/medium physical demand level. Patient's former job (patient has been fired from his job) required a heavy PDL. Office note of 11/9/07 recommended work hardening program.

A psychological evaluation of 1/15/07 is all that is available for review, and this evaluation, although it showed a normal mental status and no Axis I diagnosis, is a request for 4 weeks of a chronic pain management program. The recommendations at the end of the eval refer to a female, and it is unclear whether or not these goals relate to the stated patient or not.

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

ODG recommends cognitive-behavioral therapy for depression, stating that "the gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy." However, in this case, there is no depressed or anxious diagnosis. It is unclear what the stated goals for the patient would be in individual therapy, since there is no IT evaluation, and therefore no related goals or treatment recommendations. It also appears that patient made progress in physical therapy, and there may be a work hardening consideration.

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

**Cognitive therapy for depression: 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)

#### **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 the “at risk” patients should be by 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)

**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](#))

**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)**