

**An Independent Review  
Organization**

**835 E. Lamar Blvd.  
#394**

**Arlington, TX  
76011**

Phone:

817-274-0868

Fax:

817-549-0310

**IRO NOTICE OF DECISION TEMPLATE – WC**

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Notice of Independent Review Decision

**DATE OF REVIEW: 06/03/08**

**IRO CASE #:**

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

Individual psychotherapy 1X6; Biofeedback 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)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx year-female who was injured at work on xx/xx/xx. At the time, she was performing her job duties as an on an assembly line. She relates

she was in the process of unloading a box of paint when the paint fell off the conveyer rollers. As she was bending over to pick this up, an 80 pound box of fertilizer also fell off the rollers, hitting the left side of her head. Patient felt immediate onset of pain in her head, neck, and shoulders, and has since experienced symptoms consistent with post-concussive syndrome, to include: exacerbation of pre-existing migraine-type headaches, dizziness, nausea, memory problems, confusion, visual problems, unexpected outbursts of anger, and anxiety.

Patient consulted several doctors, and was given x-rays, MRI, and CT scan of the head, which was unremarkable. Cervical MRI indicated small annular bulges at C4 through C6. Patient has been taken off work, and since that time, patient has been treated conservatively and secondarily with chiropractic adjustments, work hardening, e-stim, passive modalities, a cortisone injection for pain, individual therapy 1x6, and medication management. Patient is currently diagnosed with Major Depressive Disorder, PTSD, postconcussion syndrome, displacement of cervical intervertebral disc without myelopathy, intractable headaches, intractable pain, anxiety, sleep disorder, and panic disorder. Chronic pain program was requested but denied. Patient currently is prescribed Xanax .5 mg tid prn anxiety, Avocet N-100 qid prn pain, and Tramadol, 50 mg qid. Request is pending for physical therapy.

On 08/24/07, patient was interviewed and evaluated by , LPC in order to make psychological treatment recommendations. At the time of the interview, patient reported an average pain level of 7/10, with a pain level range of 7/10-8/10. Mental status exam and psychometric testing revealed depressed mood, anhedonia, change in appetite, insomnia, fatigue, and diminished ability to concentrate, as well as constricted affect with irritability, anger, and anxiety. Psychosocially, patient reports distressed finances due to reduced income and she indicates that she and her husband have separated due to negative effects of the work injury.

Results of the evaluation revealed a moderate level of depression, sleep disturbance, anhedonia, muscle tension with headaches, and increased irritability. Evaluator recommended psychotherapy with the goal of supporting improved problem-solving skills, reduction in VAS self-reports of irritability, frustration, muscle tension, nervousness/physiological arousal, and sleep problems. Initial psychotherapy was denied twice by the carrier, but overturned in IRO. With the first 6 sessions, patient reported significant decreases in pain, irritability, frustration, family discord, financial stress, and sleep difficulties, thus accomplishing the initial goals set out for the beginning stages of treatment. BDI and BAI scores did not change appreciably. The current request is for 1x6 individual psychotherapy, and 1x6 biofeedback therapy with the goals of continued behavioral support, improved mood, and guiding patient in her RTW endeavors.

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

Although patient has had protracted treatment (See Delay of Treatment-ODG) 5

patient also appears to have, and has been diagnosed and treated extensively for, an injury-related chronic pain syndrome. A diagnostic interview and initial 6 IT sessions have been recommended, approved, and conducted. A stepped-care approach to treatment has been followed, as per ODG, and the requested 6 sessions of IT and biofeedback appear reasonable and necessary at this time to treat the issues arising from the patient's injury-related pain and off-work status, with a goal of increased overall physical and emotional functioning. Studies indicate that with proper treatment and early intervention, 80% of post-concussive cases resolve in the first year. Since this is a protracted case, patient can benefit from biofeedback training combined with CBT and medications management to attempt to reverse her closed head injury symptoms. Therefore, the current request is considered reasonable and medically necessary.

### ODG Work Loss Data, 2008

**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](#))

**Biofeedback:** Recommended as an option in a CBT program to facilitate exercise therapy and return to activity.

**CBT:** 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 therapy)

**Cognitive therapy:** Recommended. Cognitive behavioral psychotherapy and cognitive remediation appear to diminish psychological distress and improve cognitive functioning among persons with traumatic brain injury (TBI). ([McDonald, 2002](#)), ([Mittenberg, 2001](#)) ([Szymanski, 1992](#)) ([Tiersky, 2005](#)) ([Wood, 2004](#)) The overall benefit of in-hospital cognitive rehabilitation for patients with moderate-to-severe TBI was similar to that of home rehabilitation. ([Salazar, 2000](#)) For mild TBI, a referral for psychological services should be strongly considered three or more months post-injury if the individual is having difficulty coping with symptoms or stressors or when secondary psychological symptoms such as intolerance to certain types of environmental stimuli or reactive depression are severe. Treatment may include individual psychotherapy, marital therapy, group therapy, instruction in relaxation and related techniques, cognitive/behavioral therapy, social skills training and interventions/consultation in the community. ([Colorado, 2005](#)) There is a significant association between masculine role adherence and good outcomes among men with traumatic brain injury, but resistance to psychological help should still be discouraged. ([Schopp, 2006](#)) See also [Multidisciplinary community rehabilitation](#).

**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)

**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)