

Clear Resolutions Inc.

An Independent Review Organization

7301 Ranch Rd 620 N, Suite 155-199

Austin, TX 78726

Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: MARCH 13, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Psychotherapy x 4 Sessions

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

Adverse Determination Letters, 12/28/07, 1/24/08

ODG Guidelines and Treatment Guidelines

First report of injury

07-18-06 – 02-19-08, Med Center Notes

09-11-06, MRI report

10-09-06-05-02-07, Orthopedic Center notes

11-09-06, Dr. surgery notes

11-27-06, Post-surgical PT eval

03-13-06, RME-Dr.

04-30-06, MRI Central report

8/09/07- 1/08/08, , DC office notes

10-01-07, PPE by Diagnostics

10-17-07, Dr. new patient report

10-25-07, Dr.
11-01-07, Imagery report of right shoulder
11/13/07- 01/29/08, Dr. office notes
11/07/07-11/22/07, CPMP notes
12-13-07, Dr.
12-27-07, Dr. consult note

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 stock water bottles when he strained his low back and shoulder. Patient went to Medical Center, and received diagnosis of rotator cuff strain and participated in physical therapy 3x/week. As pain in shoulder persisted, patient was eventually diagnosed with high grade partial thickness tear, and was given a subacromial corticosteroid injection, which did not help. On 11/9/06, patient received his first shoulder surgery and then post-surgical physical treatment. In various reports available for review, he has been diagnosed with persistent high-grade articular surface supraspinatus tear, right shoulder rotator cuff tear/sprain/strain, right shoulder impingement, unspecified disorder of synovium, tendon and bursa, right shoulder pain, and chronic pain. He continued to experience pain, and eventually received a second surgery to the shoulder on 05-17-07. On 11-13-07, a third shoulder surgery was recommended for right shoulder open rotator cuff repair. Peer review indicated need for MMPI testing. Although patient was not in the tertiary stage of treatment, since surgery was still being considered, patient records indicate he completed 20 days of CPMP in November of 2007. The current request is for individual therapy 1x4.

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 available in the records for review. 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 appears that patient may require another surgery, and pre-surgical testing for treatment planning purposes has been suggested.

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 reviewer finds that Individual Psychotherapy 1x4 is not medically necessary, and upholds the previous adverse determinations.

(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 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](#))

MMPI: **Recommended to determine the existence of suspected psychological problems that are comorbid with chronic pain, to help to tailor treatment. Not recommended as an initial screening tool for all cases of chronic pain.** The MMPI and a revised version, MMPI-2, provide a psychological questionnaire that contains three validity scales and ten clinical scales that assesses the patient’s levels of somatic concern, depression, anxiety, paranoid and deviant thinking, antisocial attitudes, and social introversion-extraversion. The instrument, one of the most commonly used assessment tools in chronic pain clinics, can be useful to evaluate which behaviors and expressions related to pain are secondary to psychological stress and which are related to personality traits. The tool has not been shown to be useful as a screening tool for multidisciplinary pain treatment or for surgery. It is not recommended as an initial screening tool for general psychological adjustment in relationship to chronic pain. It cannot be used to corroborate the differential between organic and functional-based pain. Several MMPI profiles have been described in relation to pain patients:

- *Conversion V profile*: An elevation of scores on the hypochondriasis scale (scale 1, Hs) and hysteria scale (scale 3, Hy), with at least 10 points greater on these scales than on the depression scale (scale 2, D). Evidence of this profile has been interpreted as evidence of a preexisting personality that is a major contributing factor in chronic low back pain, although this is disputed. Elevations of hypochondriasis (scale 1) and hysteria (scale 3) have been found to negatively correlate with return to work.

- *“Neurotic triad”*: has been coined to describe a cluster of elevated scores of hypochondriasis, depression and hysteria. Evidence has been supportive that these scales are consistently elevated in pain patients, predicting both decreased short- and long-term pain relief. Evidence has also been found to be conflicting as to whether scales 1 and 3 are associated with functional impairment related to pain.

- *PAIN*: A clustering of pain scales based on the MMPI that was described by Costello, et al., including the following: **P**: Nearly all scales are elevated; **A**: The Conversion V profile; **I**: The “neurotic triad”; & **N**: Normal.

Criteria for Use of the MMPI:

- (a) To determine the existence of psychological problems that are comorbid with chronic pain;
- (b) To help to pinpoint precise psychological maladjustment and help to tailor treatment;
- (c) To garner information that may help to develop rapport and enhance level of motivation;
- (d) To detect psychological problems not discussed in the clinical interview. One particular area that may be helpful is the use of the Addiction Acknowledgement Scale.

([McGrath, 1998](#)) ([Ruchinskas, 2000](#)) ([Slesinger, 2002](#)) ([Chapman, 1994](#)) ([Trief, 1983](#)) ([Arbisi, 2004](#)) ([Vendrig, 2000](#))

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)