

SENT VIA EMAIL OR FAX ON
Nov/18/2008

True Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 276-1904
Email: rm@trueresolutionsinc.com

DATE OF REVIEW:
Nov/18/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Individual Psychotherapy and Biofeedback Training (EMG, TEMP, PNG) X 6 visits 1 X 6.

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)

The Individual Psychotherapy is medically necessary.
The Biofeedback is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Letters 8/6/08 and 8/18/08
Records from Injury 11/9/07 thru 8/19/08
Records from Dr. 7/17/08 thru 10/2/08

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured at work on xx/xx/xx. At the time of the injury, he was performing his usual job duties. Claimant reports that he fell from a ladder he was working on, injuring his left leg, back, and left elbow. He initially saw a company doctor, who cleaned the wounds, applied ice, put his elbow in a sling and prescribed pain medications. It is unclear whether patient was taken off work at this time. He has since transferred his care to Dr. and has been placed on continued no work status.

On 10/22/07, patient had left ulnar nerve release. He continues to report back and elbow pain, with associated numbness and tingling to the left upper extremity. He re-visited the orthopedic surgeon on 9/5/8, but report is not available for review. Medical assessment of 10/2/08 gives impressions of: internal derangement of the left elbow, left ulnar nerve entrapment status post release, neuropathic pain (left elbow, arm and hand), decreased grip and strength (left hand), cervical and lumbar displaced disk at multiple levels, and chronic

muscle contracture of the left elbow. He has decrease ROM to the left elbow, wrist, arm, hand, cervical and lumbar spine. He is prescribed Lyrica and Tramadol.

Treating physician referred the patient for a psychological evaluation to assess appropriateness for continued conservative individual therapy sessions. On 11-09-07, patient was interviewed, evaluated, and diagnosed with Mixed adjustment disorder. Records indicate he was approved for and attended 6 IT sessions, was denied chronic pain program, and attended work hardening program somewhere along the way. Re-consideration report of 8/08 seems to indicate that patient made progress across several goals during his first 6 individual therapy sessions, and the current request is for 6 more sessions. It appears that patient has decreased his anxiety from the severe to moderate range, but depression scores have increased from a 15 on the BDI to a 20. Patient also showed a decrease in self-reported symptoms of pain, depression, vocational issues, irritability, frustration, sleep problems, and forgetfulness. There was no change in perceived tension levels. Current diagnosis has been upgraded to major depression, injury-related. Patient is pending possible further surgery.

The current request is for individual cognitive-behavioral therapy 1x6 and biofeedback 1x6. Goal is to employ cognitive-behavioral techniques in order to: reduce BAI from 24 to 15, and reduce depression as measured by the BDI from 20 to 10.

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

A diagnostic interview with updated testing and recommendations was requested by the patient's treating doctor, and has been conducted. The results indicate that patient could benefit from cognitive-behavioral interventions aimed at improving coping skills in order to reduce injury-related anxious/depressed mood. A stepped-care approach to treatment has been followed, as per ODG, and the requested individual therapy sessions appear reasonable and necessary to treat the issues arising from the patient's injury-related pain and off-work status. The request for biofeedback, however, is not supported by ODG or by the patient, who reported no overall improvement in perception of his "tension" after the first 6 relaxation sessions. Therefore, the individual therapy sessions, but not the biofeedback sessions, are considered medically reasonable and appropriate at this time.

ODG Work Loss Data, 2008, Texa

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)

Bruns D. Colorado Division of Workers' Compensation, Comprehensive Psychological Testing: Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients. 200

This comprehensive review shows test name; test characteristics; strengths an

weaknesses; plus length, scoring options & test taking time. The following 26 tests are described and evaluated

1) 1) BHI™ 2 (Battery for Health Improvement – 2nd edition

- 2) 2) MBHI™ (Millon Behavioral Health Inventory)
- 3) 3) MBMD™ (Millon Behavioral Medical Diagnostic)
- 4) 4) PAB (Pain Assessment Battery)
- 5) 5) MCMI-111™ (Millon Clinical Multiaxial Inventory, 3rd edition)
- 6) 6) MMPI-2™ (Minnesota Inventory- 2nd edition ™)
- 7) 7) PAI™ (Personality Assessment Inventory)
- 8) 8) BBHI™ 2 (Brief Battery for Health Improvement – 2nd edition)
- 9) 9) MPI (Multidimensional Pain Inventory)
- 10) 10) P-3™ (Pain Patient Profile)
- 11) 11) Pain Presentation Inventor
- 12) 12) PRIME-MD (Primary Care Evaluation for Mental Disorders)
- 13) 13) PHQ (Patient Health Questionnaire)
- 14) 14) SF 36
- 15) 15) (SIP) Sickness Impact Profil
- 16) 16) BSI® (Brief Symptom Inventory)
- 17) 17) BSI® 18 (Brief Symptom Inventory-18)
- 18) 18) SCL-90-R® (Symptom Checklist –90 Revised)
- 19) 19) BDI ®–II (Beck Depression Inventory-2nd edition)
- 20) 20) CES-D (Center for Epidemiological Studies Depression Scale)
- 21) 21) PDS™ (Post Traumatic Stress Diagnostic Scale)
- 22) 22) Zung Depression Inventor
- 23) 23) MPQ (McGill Pain Questionnaire)
- 24) 24) MPQ-SF (McGill Pain Questionnaire – Short Form)
- 25) 25) Oswestry Disability Questionnair
- 26) 26) Visual Analogue Pain Scale (VAS)

All tests were judged to have acceptable evidence of validity and reliability except as noted. Tests published by major publishers are generally better standardized, and have manuals describing their psychometric characteristics and use. Published tests are also generally more difficult to fake, as access to test materials is restricted to qualified professionals. Third party review (by journal peer review or Buros Institute) supports the credibility of the test. Test norms provide a benchmark to which an individual's score can be compared. Tests with patient norms detect patients who are having unusual psychological reactions, but may overlook psychological conditions common to patients. Community norms are often more

sensitive to detecting psychological conditions common to patients, but are also more prone to false positives. Double normed tests (with both patient and community norms) combine the advantages of both methods. Preference should be given to psychological tests designed and normed for the population you need to assess. Psychological tests designed for medical patients often assess syndromes unique to medical patients, and seek to avoid common pitfalls in the psychological assessment of medical patients. Psychological tests designed for psychiatric patients are generally more difficult to interpret when administered to medical patients, as they tend to assume that all physical symptoms present are psychogenic in nature (i.e. numbness and tingling may be assumed to be a sign of somatization). This increases the risk of false positive psychological findings. Tests sometimes undergo revision and features may change. When a test is updated, the use of the newer version of the test is strongly encouraged. Document developed by Daniel Bruns, PsyD and accepted after review and revisions by the Chronic Pain Task Force, June 2001. Dr. Bruns is the coauthor of the BHI 2 and BBHI 2 tests

Comorbid psychiatric disorders: Recommend screening for psychiatric disorders. Comorbid psychiatric disorders commonly occur in chronic pain patients. In a study of chronic disabling occupational spinal disorders in a large tertiary referral center, the overall prevalence of psychiatric disorders was 65% (not including pain disorder) compared to 15% in the general population. These included major depressive disorder (56%), substance abuse disorder (14%), anxiety disorders (11%), and axis II personality disorders (70%). (Dersh, 2006) When examined more specifically in an earlier study, results showed that 83% of major depression cases and 90% of opioid abuse cases developed after the musculoskeletal injury. On the other hand, 74% of substance abuse disorders and most anxiety disorders developed before the injury. This topic was also studied using the National Comorbidity Survey Replication (NCS-R), a national face-to-face household survey. (Dersh, 2002) See also Psychological evaluations.

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)

Education (to reduce stress related to illness): Recommended. Patient education consisting of concrete, objective information on symptom management, including disease and treatment information, has been found to help reduce patient stress, especially when combined with emotional support and counseling. (Rawl, 2002)

Psychotherapy for MDD: Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. (American Psychiatric Association, 2006) See also Cognitive therapy for additional information and references, including specific ODG Psychotherapy Guidelines (number and timing of visits)

Patient selection. Standards call for psychotherapy to be given special consideration if the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans which did not involve psychotherapy

Types of psychotherapy. The American Psychiatric Association has published the following considerations regarding the various types of psychotherapy for MDD

- Cognitive behavioral psychotherapy is preferable to other forms of psychotherapy, because of a richer base of outcome studies to support its use, and because its structured and tangible nature provides a means of monitoring compliance and progress

- In contrast, psychodynamic psychotherapy is not recommended because it has specifically been identified as lacking scientific support, and is severely vulnerable to abuse because it can involve a lack of structure. (American Psychiatric Association, 2006)

Cognitive therapy for general stress Recommended. Stress management that includes cognitive therapy has the potential to prevent depression and improve psychological and physiological symptoms. As with all therapies, an initial trial may be warranted, with continuation only while results are positive. (Mino, 2006) (Granath, 2006) (Siversten, 2006)

Biofeedback: Not recommended as a stand-alone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. There is fairly good evidence that biofeedback helps in back muscle strengthening, but evidence is insufficient to demonstrate the effectiveness of biofeedback for treatment of chronic low back pain. Biofeedback may be approved if it facilitates entry into a CBT treatment program, where there is strong evidence of success. As with yoga, since outcomes from biofeedback are very dependent on the highly motivated self-disciplined patient, we recommend approval only when requested by such a patient, but not adoption for use by any patient. There is conflicting evidence on the effectiveness of biofeedback for treating patients with chronic low back problems. See the Pain Chapter for more information and references, as well as ODG biofeedback therapy guidelines. (van Tulder, 1997) (Bigos, 1999)

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 week

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-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)