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Notice of Independent Review Decision

DATE OF REVIEW:
10/16/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Individual psychotherapy once weekly for six weeks (total of six sessions) CPT code 90806.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board Certified Clinical Psychologist

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Overturned**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.
The requested individual psychotherapy once weekly for six weeks (total of six sessions); CPT code 90806 is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 10/06/08 letter from Pre-Authorization Director
- 10/03/08 MCMC Referral
- 10/02/08 Notice To Italicization Review Agent Of Assignment
- 10/02/08 Notice Of Assignment Of Independent Review Organization
- 10/02/08 Notice To MCMC, LLC Of Case Assignment
- 10/02/08 Confirmation Of Receipt Of A Request For A Review, DWC
- 09/30/08 Request For A Review By An Independent Review Organization
- 09/25/08 letter from RN Case Manager
- 09/23/08 Reconsideration: Health Individual Psychotherapy Preauthorization Request (cover sheet)
- 09/23/08 Reconsideration: Health Individual Psychotherapy Preauthorization Request, MS, CRC, LPC,
- 09/22/08 Fax cover sheet with Remarks from Neurological Surgery Associates
- 09/03/08 letter from RN Case Manager
- 09/24/08, 09/02/08 Environmental Intervention notes, Ph.D
- 08/28/08 Fax Cover Sheet with Comments from Ph.D
- 08/28/08 Health Individual Psychotherapy Preauthorization Request

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- 08/14/08 referral form
- 08/01/08 Patient Face Sheet
- 08/01/08 Initial Behavioral Medicine Consultation, MA, LPC,
- 09/02/08, 08/01/08 chart note, M.D.
- 04/17/08 Operative Report, M.D., Medical Center
- 04/07/08 report from M.D., Orthopedic Associates (page 2 only)
- 12/11/07 MRI left knee, Diagnostic Imaging
- 07/26/07 MRI left knee, Imaging
- 05/06/07 Report of Operation, M.D., Medical Center (first page only – poor quality)
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual sustained a work injury on xx/xx/xx while performing her duties She slipped, missed a step, and injured her left knee. She sought emergency room care the same day. Despite aggressive medical care including an arthroscopic intervention on 09/06/2007, her knee pain has escalated. Additional surgery failed to alleviate her pain. This additional surgery was completed on 04/17/2008. She has been unable to return to work. She was referred to a CARF certified program for assistance and evaluation for their Return to Work (RTW) program. She was not approved for the RTW program, but her attending provider (AP) referred her for counseling.

An evaluation on 08/01/2008 documented the presence of escalating pain (VAS=6-10/10). This is above the average for patients presenting to a Chronic Pain Management Program (CPMP). She was also found to have high depression, insomnia, and anxiety levels. The AP requested six Individual Psychotherapy (IPT) sessions.

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

The injured individual was psychologically examined and diagnosed with depression following an industrial injury to her left knee. 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. The use of the Beck Inventories test is endorsed in ODG (see reference) and is well-accepted in the psychological community and is well within the “standard of care” of psychologists who frequently use it in similar situations. It has been well-established that treatment of work-related injuries may require evolution to a biopsychosocial methodology if pain is of sufficient chronicity. Most experts in the field usually endorse a time-span of three to six months as meeting this criterion (IASP, 1986). At this point, there is medical consensus that a biopsychosocial approach is necessary to address the multifaceted issues usually present.

TDI has adopted ODG as providing peer-reviewed published guidelines. These guidelines provide clear guidance:

> 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

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(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:

Provided documentation supports the injured individual has chronic pain (greater than15 months) and a psychodiagnostic evaluation presented clear evidence of insomnia, depression, and anxiety. Documentation reviewed and review of the published peer-review guidelines support the biopsychosocial care requested is medically necessary.

CRITERIA: Official Disability Guideline (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:

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- 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)

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 weeks
- 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)

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

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.

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines: 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) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003) See "Psychological Tests Commonly Used in the Assessment of Chronic Pain

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Patients" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI 2nd ed - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superceded by the MBMD following, which should be administered instead], (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI–II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale – VAS. (Bruns, 2001) Chronic pain may harm the brain, based on using functional magnetic resonance imaging (fMRI), whereby investigators found individuals with chronic back pain (CBP) had alterations in the functional connectivity of their cortical regions - areas of the brain that are unrelated to pain - compared with healthy controls. Conditions such as depression, anxiety, sleep disturbances, and decision-making difficulties, which affect the quality of life of chronic pain patients as much as the pain itself, may be directly related to altered brain function as a result of chronic pain. (Baliki, 2008) See also Comorbid psychiatric disorders. See also the Stress/Mental Chapter.

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE:

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

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

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.

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

Maloney, K et al. An overview of outcomes research and measurement. *J Health Care Quarterly*, 1999; Nov-Dec; 21(6):4-9.

Lambert MJ, editor. Bergin and Garfield's handbook of psychotherapy and behavior change. 5Th ed. John Wiley and Sons, New York. 2004.

Gatchel, Robert J., *Clinical Essentials of Pain Management*, 2005, American Psychological Association.

Turk, D.C. & Gatchel, R.J. (Eds.). Psychological Approaches to Pain Management: A Practitioner's Handbook, Second Edition. New York: Guilford Press, 2002.