

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX 75038
972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 13, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed 6 sessions of individual psychotherapy

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

This case was reviewed by a clinician with a Ph.D. in clinical Psychology and who is licensed in the State of Texas. The reviewer specializes in general psychology and behavioral pain management and is engaged in full time practice.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- XX Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
309.3	90806		Prosp	6					Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-14 pages

Respondent records- a total of 179 pages of records received to include but not limited to: Employers first report of injury, xx/xx/xx; Notes 8/01/07-8.3.07; , DO, office notes; 8/10/07-9.19.08; Daily PT progress notes; 8/10/07-10/12/07;PPE; 8/16/07; medical cervical ultrasound of 8/20/07; EEG/NCS 10/11/07;Cervical spine exam, 8.1.07, 8.10.07; Cervical MRI 10/21/07, 10.25.07; FCE 8.16.07, 12/13/07, 8.25.08; RME 8.1.08, evaluation center; 12/14/07; notes: Dr.

8.1.07; Dr. 8.1.07; Dr. 8.10.07; Dr. 8.20.07; Dr. K 8.20.07; Dr. 10.21.07; Behavioral Medicine Eval; 6/9/08; Letters of Denial; 7/17/08 and 8/12/08; RME; , MD; 8/01/08; Appeal letter; 8/05/08; , Md office note; 10.11.07-8/8/08; Request for IRO; 9/19/08

Requestor records- a total of 39 pages of records received to include but not limited to: Records from Dr. 6.9.08-9.19.08; Denial letters 7.17.08-8.12.08; PT notes 8.10.07-12.3.07; RME 12.14.07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female who was injured at work on xx/xx/xx. At the time, she was performing her usual job duties as a for . Claimant reports that a number of heavy boxes fell from overhead off a co-worker's pallet, striking her in the back of the head and neck region. She was knocked to the ground. Records for review are discrepant about whether or not there was a loss of consciousness, but patient did eventually receive a diagnosis of post-concussive syndrome as well as cervical disc injury. This pain continues to be felt by the patient, and it is described by her as intermittent, sharp pain in her neck and head. She rates her pain as 8/10 VAS, and states the pain increases with turning her head to the right, includes muscle spasms, and impairs her sleep. Patient established treating with Dr. and has been returned to work full time, with restrictions on lifting over 10 pounds.

Patient has received the following diagnostics and treatments to date: x-rays, MRI (inconclusive), EMG (negative), PPA, physical therapy, injections, FCE, psychological evaluation, and medications management. Patient is currently prescribed Hydrocodone for pain and Flexeril for muscle spasms. Office note of 8/8/08 recommended RTW full duty after FCE. FCE of 8/25/08 revealed patient to be at the light-medium physical demand level, and able to return to work, with restrictions.

On 6/9/08, patient was evaluated by , PhD, to determine whether she would be appropriate for a trial of individual therapy. Patient was referred by her treating doctor for significant, persistent pain symptoms, as well as emotional symptoms. An interview with testing was conducted. Results of the BAP-MSQS testing showed severe perception of pain, with medications, moderate perceived depression and mild level of anxiety and tension related to her pain problem and physical limitations. Results of the TSK showed patient falling into the elevated range and indicated excessive, irrational, debilitating fear of physical movement and activity. PAIRS score was 78, indicating disability mindset, BDI was 17 (high mild), and BAI was 6. Item analysis from BDI showed patient ascribing to anhedonia, poor appetite, insomnia, fatigue, and stating "I cry all the time". BAI revealed patient ascribing to difficulty breathing, fear of dying, and inability to relax. Patient was diagnosed with adjustment disorder with depressed mood and pain disorder. Individual therapy 1x6 was requested. Goals for therapy are: to use cognitive-behavioral therapy to decrease depression and relaxation training to decrease physical tension. Treatment plan also includes increased education and practice of pain management techniques, improved coping skills, and reduction of disability mindset.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

A diagnostic interview with 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 and relaxation interventions aimed at improving coping skills in order to reduce injury-related pain, depressed mood, disability mindset, and poor sleep, in an effort to keep patient at work and improve her ability to stay at work over the long haul. A stepped-care approach to treatment has been followed, as per ODG, and the requested evaluation and sessions appear reasonable and necessary to treat the issues arising from the patient's injury-related pain and

restricted-work status, with a goal of increased overall physical and emotional functioning. The ODG has been accepted as the standard of care by TDI-TWC, and it is clear that these guidelines, correctly applied, could only lead to the establishment that this request is considered medically reasonable and necessary at this time.

ODG Work Loss Data, 2008, Texas

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. 2001](#)

This comprehensive review shows test name; test characteristics; strengths and 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 Inventory
- 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 Profile
- 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 Inventory
- 23) 23) MPQ (McGill Pain Questionnaire)
- 24) 24) MPQ-SF (McGill Pain Questionnaire – Short Form)
- 25) 25) Oswestry Disability Questionnaire
- 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.

Rating: 7a

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](#))

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 sessions)

Buchner M, Zahlten-Hinguranage A, Schiltenwolf M, Neubauer E. Therapy outcome after multidisciplinary treatment for chronic neck and chronic low back pain: a prospective clinical study in 365 patients. *Scand J Rheumatol.* 2006 Sep-Oct;35(5):363-7.

Department of Orthopaedic Surgery, University of Heidelberg, Germany. Matthias.Buchner@ok.uni-heidelberg.de

OBJECTIVES: This prospective longitudinal clinical study analyses the therapy outcome of 365 patients with either chronic neck (n = 134) or low back (n = 231) pain treated with a multidisciplinary biopsychosocial therapy approach. **METHODS:** Patients with chronic neck pain (NP) or low back pain (LBP) for 3 months or longer, corresponding sick leave for longer than 6 weeks, and clearly defined inclusion and exclusion criteria underwent a 3-week standardized inpatient multidisciplinary biopsychosocial therapy. Baseline sociodemographic, occupational, functional, and psychological data at entry into the study (T0) were comparable in both groups. At the 6-month follow-up (T1), five different therapy outcomes were analysed in both groups: back-to-work status, generic health status (the 36-item Short Form Health Survey, SF-36), pain intensity (visual analogue scale), functional capacity (Hannover back capacity score), and satisfaction with the therapy. **RESULTS:** Both treatment groups improved significantly in all outcome criteria between T0 and T1. In the total group, the back-to-work rate was 67.4%. At the final follow-up there were no significant differences between the group with chronic NP and the group with chronic LBP in the outcome criteria back-to-work status, improvement of health status and functional capacity, satisfaction with therapy, and reduction of pain. **CONCLUSION:** Evaluation of the main results of this study suggests that patients with chronic NP also derive significant benefit from a multidisciplinary treatment strategy, demonstrated in the literature so far mainly for patients with chronic LBP.

PMID: 17062436

Andersen JH, Kaergaard A, Frost P, Thomsen JF, Bonde JP, Fallentin N, Borg V, Mikkelsen S. Physical, psychosocial, and individual risk factors for neck/shoulder pain with pressure tenderness in the muscles among workers performing monotonous, repetitive work. *Spine.* 2002 Mar 15;27(6):660-7.

Department of Occupational Medicine, Herning Hospital, Herning, Denmark. hecjha@ringamt.dk

Abstract:

CONCLUSIONS: "Work-related physical and psychosocial factors, as well as several individual risk factors, are important in the understanding of neck/shoulder pain. The findings suggest that neck/shoulder pain has a multifactorial nature. Reduced health-related quality of life is associated with subjective pain and clinical signs from the neck and shoulders."

Publication Type: Case Control, 3123 Cases

Rating: 3a

MDD treatment, mild presentations: Recommend options as indicated below. A "mild" manifestation is defined as involving five to six of the diagnostic criteria for a major depressive episode, and a similarly mild presentation of impairment. ([American Psychiatric Association, 2000](#)) Treatment options:

A. Psychotherapy: Cognitive behavioral psychotherapy (CBT) has received a clear recommendation for such mild presentations, from the American Psychiatric Association's Practice Guidelines. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of psychotherapy, and those considerations are summarized in the

Procedure Summary, [Psychotherapy for MDD](#) (Major Depressive Disorder) - *Patient selection*. ([American Psychiatric Association, 2006](#))

B. Medication: Current practice standards defer to patient preference for much of the treatment planning. ([American Psychiatric Association, 2006](#)) One example is a recommendation that antidepressant medication is an option for such mild presentations, ***IF*** the patient prefers medication over psychotherapy. The American Psychiatric Association has published additional considerations in regard to various types of anti-depressant medications, and those considerations are summarized in the Procedure Summary, [Antidepressants for treatment of MDD](#) (major depressive disorder). ([American Psychiatric Association, 2006](#)) A randomized controlled trial has indicated that the patient's smoking status is a credible factor that can be considered in the treatment plan. Specifically, anti-depressant medication (fluoxetine/Prozac) has been found to compromise the success of smoking cessation efforts. ([Spring, 2007](#)) Subsequently, if the patient is attempting to quit smoking, that effort causes anti-depressant medication to be a less attractive treatment option than standards typically indicate.

C. Combined use of both psychotherapy and medication: Another example of the tendency for professional standards to defer to patient preference is a recommendation for a combined use of psychotherapy and antidepressant medication for mild presentations of MDD, ***IF*** the patient prefers such an approach. ([American Psychiatric Association, 2006](#)) The standards also call for this combined approach ***IF*** the presentation of MDD involves significant social issues/interpersonal problems. ([American Psychiatric Association, 2006](#)) The considerations that were referenced above in regard to psychotherapy and medication options can also be applied to considerations of using both together

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- XX PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (SEE ABOVE)
- XX OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (SEE ABOVE)