Notice of Independent Review Decision

DATE OF REVIEW:
04/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
CPT code 90806: individual psychotherapy once a week for four weeks; and CPT code 90901: biofeedback training once a week for four weeks (electromyogram, PNG, and TEMP).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board Certified 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 four (4) sessions of individual psychotherapy (CPT-90806) and four (4) biofeedback training sessions (CPT-90901) are medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 04/03/09 letter from ,
- 04/03/09 letter from , IRO Coordinator,
- 04/03/09 Independent Review Organization Summary, Claims Management
- 03/31/09 MCMC Referral
- 03/31/09 Notice Of Assignment Of Independent Review Organization, , DWC
- 03/31/09 Notice to MCMC, LLC Of Case Assignment, , DWC
- 03/30/09 Confirmation Of Receipt Of A Request For A Review, DWC
- 03/27/09 Request For A Review By An Independent Review Organization
- 03/11/09 Review Outcome letter,
- 03/06/09 Environmental Intervention note, , Ph.D.,
- 03/04/09 Reconsideration: Behavioral Health Individual Psychotherapy & Biofeedback Therapy Preauthorization Request,
- 03/04/09 Reconsideration: Behavioral Health Individual Psychotherapy & Biofeedback Therapy Preauthorization Request letter, , MS,
- 02/11/09 Review Outcome letter,
- 02/10/09 Environmental Intervention note, , Ph.D.,
- 02/06/09 Behavioral Health Individual Psychotherapy Preauthorization Request,
- 12/12/08 Treatment Summary/Reassessment, , M.A.,

- 12/11/08 referral form,
- 08/20/08 (Admit Date) Attestation Statement,
- 08/20/08 Observation Services P&P
- 08/19/08 to 08/28/08 Practitioner's Orders,
- 08/19/08 (Procedure date) Operative Orders, , M.D.
- 08/19/08 History & Physical, , M.D.
- 08/19/08 Report of Operation, , M.D.,
- 08/19/08 Operative Report, , M.D.,
- 08/13/08 Examination Report, , M.D.
- 08/06/08 Individual Psychotherapy Note, , Ph.D.,
- 07/30/08 Examination Report, , M.D.
- 07/02/08 Work Status Report, DWC
- 07/02/08 Examination Report, , M.D.
- 06/26/08 Initial Behavioral Medicine Consultation, , LPC-Intern,
- 06/26/08 Addendum, , LPC-Intern
- 06/04/08 Examination Report, , M.D.
- 05/21/08 Work Status Report, DWC
- 05/21/08 New Patient note, , M.D.
- 04/23/08 Examination Report, , M.D.
- 04/21/08 Work Status Report, DWC
- 04/21/08 doctor's note,
- 04/14/08 Emergency Physician Record,
- 04/14/08 Summary Report,
- 04/14/08 Emergency Nursing Record,
- 04/14/08 Department Record,
- 04/14/08 Patient Instructions Signature Page,
- 04/14/08 left knee radiographs,
- 03/26/08 office note, , M.D.
- 03/20/08 Final Cumulative Report,
- 03/19/08 Emergency Services Nursing Record,
- 03/19/08 Emergency Physician Record,
- 03/19/08 chest radiographs
- 03/19/08 office note, ,
- 03/19/08 CT angiography of chest
- 03/19/08 ultrasound Doppler venous lower extremity left
- 03/17/08 Exit Interview
- 03/16/08 left knee radiographs
- 03/16/08 Report to Employer – Medical Treatment of Employee,
- 03/16/08 Emergency Physician Record,
- 03/15/08 Emergency Services Nursing Record,
- 12/12/07 Work Status Report, DWC
- 12/12/07 Lower Extremity exam,
- 12/04/07 MRI left knee,
- 11/28/07 Lower Extremity exam,
- 11/09/07 Patient Face Sheet,

- 11/09/07 Associate Statement – Workers Compensation
- 11/09/07 Employer's First Report of Injury or Illness
- 11/09/07 Emergency Physician Record,
- 11/09/07 Emergency Department Ongoing Nursing Assessment,
- 11/09/07 Emergency Department Musculoskeletal Nursing Assessment,
- 11/09/07 Initial Assessment Form,
- 11/09/07 Order Procedure Form – Orthopedic Emergencies,
- 11/09/07 Work/School Release Form,
- 11/09/07 left knee radiographs,
- 11/05/07 Notice of Disputed Issue and Refusal to Pay Benefits, Claims Management
- Undated note from , Supervisor,
- Undated IRO Decision instructions, DWC
- Undated Work Status Report, DWC
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a at . She injured her knee in the course of her duties, fell and also injured her tail bone. Physically, she has been seeing Dr. , a chiropractor. She was referred to Dr. , a clinical psychologist. After a psychological evaluation, Dr. diagnosed a major depressive disorder and generalized anxiety disorder. Dr. proceeded to provide individual psychotherapy to the injured individual between 10/08/2008 and 12/08/2008. Dr. reported "the patient has definitely benefited from treatment". This is supported by submitted documentation. Following completion of ten psychotherapy sessions, four individual psychotherapy sessions were requested. Dr. submitted a request for four additional sessions of psychotherapy and the initial four sessions of biofeedback training.

The basis for prior adverse decisions was their opinion that insufficient progress was demonstrated in the previous sessions of psychotherapy provided to the injured individual. There is no specific standard for determining "sufficient progress". However on five measures of progress submitted by Dr. , the injured individual improved. Improvements range from 10% to 40%. This appears to represent a reasonable basis for determining that sufficient progress was achieved to support additional psychotherapy sessions. Official Disability Guidelines suggest that up to twenty sessions of individual psychotherapy may be approved if evidence of treatment efficacy is demonstrated. Approval of for additional psychotherapy sessions appears to fall within Official Disability Guidelines.

Biofeedback treatment is supported by Official Disability Guidelines as long as it is not offered as a stand-alone treatment. In this case, Dr. was attempting to offer biofeedback training in conjunction with cognitive behavioral therapy. ODG supports such an application.

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

The injured individual was injured while working for . She developed significant refractory chronic pain as result of this injury. Her chronic pain condition included the development of irritability, insomnia, and depression. The medical "gold standard" or treating refractory chronic pain includes a multidisciplinary approach incorporating the services of psychologists. Typically, injured individuals suffering from chronic pain will need cognitive behavioral therapy and occasionally biofeedback

services. These services have been established as effective in the amelioration of refractory chronic pain. Both of these procedures are recommended by Official Disability Guidelines.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines: 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:

- 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).

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 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. EMG biofeedback may be used as part of a behavioral treatment program, with the assumption that the ability to reduce muscle tension will be improved through feedback of data regarding degree of muscle tension to the subject. The potential benefits of biofeedback include pain reduction because the patient may gain a feeling that he is in control and pain is a manageable symptom. Biofeedback techniques are likely to use surface EMG feedback so the patient learns to control the degree of muscle contraction. The available evidence does not clearly show whether biofeedback's effects exceed nonspecific placebo effects. It is also unclear whether biofeedback adds to the effectiveness of relaxation training alone. The application of biofeedback to patients with CRPS is not well researched. However, based on CRPS symptomology, temperature or skin conductance feedback modalities may be of particular interest. (Keefe, 1981) (Nouwen, 1983) (Bush, 1985) (Croce, 1986) (Stuckey, 1986) (Asfour, 1990) (Altmaier, 1992) (Flor, 1993) (Newton-John, 1995) (Spence, 1995) (Vlaeyen, 1995) (NIH-*JAMA*, 1996) (van Tulder, 1997) (Buckelew, 1998) (Hasenbring, 1999) (Dursun, 2001) (van Santen, 2002) (Astin, 2002) (State, 2002) (BlueCross BlueShield, 2004) This recent report on 11 chronic whiplash patients found that, after 4 weeks of myofeedback training, there was a trend for decreased disability in 36% of the patients. The authors recommended a randomized-controlled trial to further explore the effects of myofeedback training. (Voerman, 2006) See also Cognitive behavioral therapy (Psychological treatment) and Cognitive intervention (Behavioral treatment) in the Low Back Chapter. Functional MRI has been proposed as a method to control brain activation of pain. See Functional imaging of brain responses to pain.

ODG biofeedback therapy guidelines:
Screen for patients with risk factors for delayed recovery, as well as motivation to comply with a treatment regimen that requires self-discipline.
Initial therapy for these “at risk” patients should be physical therapy exercise instruction, using a cognitive motivational approach to PT.
Possibly consider biofeedback referral in conjunction with CBT after 4 weeks:
- 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)
- Patients may continue biofeedback exercises at home

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

1) *Handbook of Pain Syndromes*. Mahwah, NJ: Lawrence Erlbaum Publishers, 1999-pages 77-97.
2) 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.
3) Nielson, W.R. & Weir, R. (2001). "Biopsychosocial approaches to the treatment of chronic pain." *Clinical Journal of Pain*, 17(4 Suppl), S114-S127.
4) 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.
5) Flor, H., D. J. Behle, et al. (1993). "Assessment of pain-related cognitions in chronic pain patients." *Behav Res Ther* 31(1): 63-73.
6) Maloney, K et al. An overview of outcomes research and measurement. *J Health Care Quarterly*, 1999; Nov-Dec; 21(6):4-9.
7) Lambert MJ, editor. Bergin and Garfield's handbook of psychotherapy and behavior change. 5Th ed. John Wiley and Sons, New York. 2004.
8) Gatchel, Robert J., *Clinical Essentials of Pain Management*, 2005, American Psychological Association.
9) Turk, D.C. & Gatchel, R.J. (Eds.). Psychological Approaches to Pain Management: A Practitioner's Handbook, Second Edition. New York: Guilford Press, 2002.