

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** FEBRUARY 16, 2009

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical Necessity of proposed 6 sessions of psychotherapy (90806)

### **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
724.2	90806		Prosp	6					Overturned

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-15 pages

Respondent records- a total of 31 pages of records received to include but not limited to:  
notes 11.7.08-12.23.08; study 1.21.08; report, Dr. notes 7.9.08-7.29.08; note 7.29.08

Respondent records- a total of 150 pages of records received to include but not limited to:  
DWC form1; email from , 1.22.09; case summary 12.2.08; notes, Dr 1.16.08-11.7.08; notes, Dr. , 3.25.08; report 3.19.08-9.26.08; progress note 9.3.08; plans; DWC various 73; note 7.29.08; benefits; MRI Lumbar 1.21.08; note, Dr. 12.14.07-1.23.08; DWC 60; DDE report

6.30.08; statement; 4.26.08; Sentry Insurance letter 3.6.08; Myelogram Spine Lumbosacral 3.24.08; CT Lumbar 3.24.08

Requestor records- a total of 11 pages of records received to include but not limited to: PHMO Notice of IRO;\_Nuevda Vida Behavioral Health Associates notes 11.7.08

### **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 , where she had been employed for the last 4 years. She was in the process of getting up from her desk to go over toward a bulletin board when she tripped over boxes that were on the floor, and fell, landing on her hands and knees. She describes the initial pain as low back pain which radiated into her right LE. Patient established treating with MD, and was taken off work. Since then, she has attempted to return to work from April 13, 2008 until May 1, 2008. The severe pain necessitated release to an off-work status on June 19, 2008. Since then, she has not returned to work.

Claimant has received the following diagnostics and treatments to date: X-rays, Lumbar MRI's, physical therapy eval, EMG/NCV, CT scan, Myelogram, and medications management. Medications include Darvocet, Hydrocodone, Cymbalta, Flexeril, Seroquel, Ambien, Nexium, Zomig, and Inderal. Patient has a history of lumbar interbody fusion on L5-S1 on June 29, 1999, with full rehab from the injury. In 2001, her right leg was broken at the tibia, which required surgery with pin inserted. Due to her pre-existing issues, current case has been disputed regarding compensability issues. However, designated doctor visit of 08/01/08 decided compensable injury was low back pain due to strain/sprain, objective signs of radiculopathy, absent ankle jerks, post laminectomy pain, possible pain from instrumentation, low back pain, and right tibia rod pain. Her treating physician has referred her for physical therapy, and eval done 7/29/08 showed worsening of symptoms to include right LE numbness that has resulted in multiple falls. Patient showed functional deficits of severe problems with light chores, floor transfers, kneeling, and lift/carry 15-20 pounds, and moderate problems with going up and down stairs and sleep. Recommendation was for physical therapy 1x12 and referral for psychological exam to address high fear-avoidance beliefs as measured by the FABQ, symptoms of depression, anxiety, non-organic signs, and sleep disturbance. Physician note of 9/1/08 showed patient experiencing low back pain, radiculopathy, muscle spasms, and stiffness, and referral to an orthopedist for her right leg pain was made.

Patient has subsequently been referred for a psychological evaluation to assess appropriateness for individual therapy. On 11-07-08, patient was interviewed and evaluated by , LPC, in order to make psychological treatment recommendations. As a result, patient was diagnosed with an adjustment disorder with mixed anxiety and depressed mood and occupational problems.

Results of the testing and interview show that patient continues to struggle with pain at an average 4/10 level. On the Pain Experience Scale, she scored a 68, indicating a moderate level of emotional and worry responses. On the McGill Pain Questionnaire, she scored a 52, indicating pain experience in the severe to debilitating range. She scored a 56% on the Oswestry, indicating severe problems with pain interference with sleep, walking, sitting, or standing for prolonged periods of time. Patient's BDI was a 23 and BAI was a 28, both in the moderate range. Patient reports associated lifestyle changes to include increased marital tension, lowered self-esteem, and decreased involvement in family activities. Mental status showed patient's attitude was open and cooperative; affect was depressed with bouts of crying spells.

Goal is to employ cognitive-behavioral and relaxation therapy to address depression, anxiety, and poor sleep. Positive coping strategies will be introduced along with patient education regarding the biopsychosocial aspect of chronic pain.

**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/GUIDLEINES 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 interventions aimed at improving coping skills in order to reduce problems with sleep, depression and anxiety. 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 off-work status with a goal of increased overall physical and emotional functioning.

**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)

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](#))

**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)

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES