



**DATE OF REVIEW:** 06/17/09

**IRO CASE #:**

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

4 Sessions of Individual Psychotherapy

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

Clinical Psychologist

**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)

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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Employer's First Report of Injury or Illness, Hospital System, xx-xx-xx
- Evaluation, , 07/07/08, 07/08/08, 07/11/08, 07/15/08
- X-rays of Lumbar Spine and Left Hip, , 07/07/08
- Spine Assessment, , 07/11/08
- Physical Therapy Evaluation Summary, , 07/11/08
- Pain Drawing, 07/11/08
- Pain Scale, 07/11/08
- Visual Analogue Scale, 07/11/08

- Evaluation, , M.D., 07/16/08, 07/25/08, 08/20/08, 09/10/08, 10/17/08, 11/19/08, 12/31/08, 02/02/09, 02/18/09, 03/25/09, 04/22/09
- Approved Outpatient Physical therapy 9 Sessions, , 07/16/08
- Computerized Muscle Testing (CMT) & Range of Motion (ROM), Therapy & Diagnostics, 07/16/08, 08/20/08, 09/10/08, 10/17/08, 11/19/08, 12/31/08, 02/02/09, 02/18/09, 04/22/09
- MRI Lumbar Spine, M.D., 07/21/08
- Denial of Foramen Epidural, , 07/31/08
- Electro-Diagnostic Interpretation, M.D., 08/12/08
- Denial of Sag-Coro Rigid Frame Pre, , 08/13/08
- Denial of Paravertebral Injection, , 09/12/08
- Outpatient Therapy & Physician Services Prescription, Dr., 10/06/08
- Lumbar Evaluation, Medical Center, 10/09/08
- Outpatient Medical Profile/Learning Needs, Rehabilitation System, 10/09/08
- Physical Therapy Patient Education, Medical Center, 10/09/08
- Treatment Record Medical Center, 10/09/08, 10/20/08, 10/22/08, 10/28/08, 10/31/08, 11/03/08, 11/17/08
- Exercise Flow Sheet, Medical Center, 10/20/08, 10/22/08, 10/28/08, 10/31/08, 11/03/08, 11/17/08
- Approval for 10 Sessions of Physical Therapy, 10/15/08
- Approval Foramen Epidural Injection, , 10/24/08, 01/08/09
- Right L4 and L5 Transforaminal Root Block, Dr. 11/05/08, 11/07/08
- Post Anesthesia Care Unit Orders, Hospital, 11/05/08
- Physician's Orders, Hospital 11/05/08
- Pregnancy Test, Hospital, 11/05/08
- Anesthesia Report, Hospital, 11/05/08
- Post Anesthesia Record, Hospital, 11/05/08
- Medications, Hospital 11/05/08
- Re-Evaluation, Medical Center, 11/17/08
- Physical Therapy, Rehabilitation System, 11/21/08, 12/12/08
- Denial of Foramen Epidural Injection, , 11/24/08
- Day Surgery Pre-Operative Nursing Record, Hospital 01/14/09
- Day Surgery Post-Operative Nursing Record, Hospital, 01/14/09
- Anesthesia Report, Hospital, 01/14/09
- Post-Anesthesia Care Unit Orders, Hospital, 01/14/09
- Physician's Orders, Hospital, 01/14/09
- Pregnancy Test, Hospital, 01/14/09
- Post Anesthesia Record, Hospital, 01/14/09
- Medications, Hospital 01/14/09
- Designated Doctor Evaluation (DDE), , M.D., 02/06/09
- Initial Evaluation, , D.O., 03/19/09
- Evaluation, , M.A., L.P.C.
- Physical Performance Evaluation (PPE), Healthcare Systems, 03/24/09
- Approval for Sacroiliac Joint Injection, , 03/27/09

- Pre-Certification Request for Individual Psychotherapy, Healthcare Systems, 03/30/09
- Peer to Peer, , Ph.D., 04/01/09
- Day Surgery Pre-Operative Nursing Record, Hospital, 04/03/09
- Physician's Orders, Hospital 04/03/09
- Pregnancy Test, Hospital, 04/03/09
- Operative Report, Dr., 04/03/09
- Anesthesia Report, Hospital, 04/03/09
- Post Anesthesia Record, Hospital 04/03/09
- Medications, Hospital, 04/03/09
- Post Anesthesia Care Unit Orders, Hospital 04/03/09
- Day Surgery Post-Operative Nursing Record, Hospital, 04/03/09
- Discharge Summary, Dr., 04/03/09
- Request for an Appeal, Healthcare Systems, 04/22/09
- Denial Letter, , 05/01/09
- Peer to Peer, , Ph.D., 05/01/09
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient slipped and fell on a wet floor while at work, falling flat on her buttock region. She underwent physical therapy, MRI's, injections, individual counseling and was treated with Zanaflex, Skelaxin, Lyrica, Cymbalta, Talacen, and Relafen.

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

The four requested sessions of individual psychotherapy are medically reasonable and necessary. The documentation provided indicates a verifiable medical diagnosis.

The behavioral medicine consultation performed by M.A., L.P.C., on xx-xx-xx provides a thorough evaluation, adequate documentation and objective testing to establish the diagnosis of a Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, Chronic (307.89), Reactive Depression (311.0) and Anxiety state, unspecified, reactive anxiety (300.00). Treatment goals were clearly spelled out for the four requested treatment sessions. The appeal of the denial by Ms. again spells out the appropriate ODG rationale for this treatment.

The documentation suggested that the patient was psychological functional and not suffering from a psychological disorder at the time of her injury. It was noted that "the patient has no history of previous mental health treatment and no previous inpatient psychiatric hospitalization. She has never been diagnosed with a psychiatric disorder and has no history of previous neuropsychological head injury". The patient was also prescribed antidepressant medication (Cymbalta) which is recommended in the ODG in

conjunction with psychotherapy. There was objective test data BDI-II, BAI and FABQ demonstrating depression, anxiety and psychological sequelae secondary to the patient's injury.

In addition to the thorough evaluation provided by Ms. the designated doctor states that "Ms. received conservative treatment consisting of work cessation, medication, and a course of physical rehabilitation that caused exacerbation and was discontinued after six sessions". This documentation clearly demonstrates the need for the psychological consultation and intervention. It is irrelevant as to whether the patient had three or six sessions of PT. The ODG states "consider separate psychotherapy CBT referral after four weeks if lack of progress from PT alone".

The patient is clearly experiencing injury related depression, anxiety and psychological sequelae as well as chronic pain and the guidelines are clear concerning the recommendation for psychotherapy (see complete guidelines listed below). The patient was also provided with the appropriate antidepressant medication which further supports the need for psychotherapy to be combined with this medication.

**ODG Psychotherapy Guidelines:** 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). (DeRubes, 1999), (Goldapple, 2004). An additional study found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997). A recent Meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. The gold standard for the evidence based treatment of MDD is a combination of medication (antidepressant) and psychotherapy. **ODG Psychotherapy Guidelines:** Initial trial of six visits over six weeks. With evidence of objective functional improvement, total of up to 13-10 visits over 13-20 weeks.

**ODG Recommended:** Mind/body intervention programs have been shown to reduce perceived stress and anxiety. One clinical trial on college students tested the effect of a mind/body intervention (consisting of six 90-minute group-training sessions in relaxation response and cognitive behavioral skills) to reduce stress and found that significantly greater reductions in psychological distress, anxiety, and perceived stress were found in the experimental group. (Deckro, 2002).

**Cognitive therapy for general stress:** ODG 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)

Cognitive Therapy 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 post-traumatic 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 option, 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).

Behavioral Treatment. ODG Recommended. Behavioral treatment may be an effective treatment for patients with chronic low back pain, but it is still unknown what type of patients benefit most from what type of behavioral treatment. Some studies provide evidence that intensive multidisciplinary bio-psycho-social rehabilitation with a functional restoration approach improves pain and function. (Newton-John, 1995) (Hasenbring, 1999) (van Tulder-Cochrane, 2001) (Ostelo-Cochrane, 2005) (Airaksinen, 2006) (Linton, 2006) (Kaapa, 2006) (Jellema, 2006) Recent clinical trials concluded that patients with chronic low back pain who followed cognitive intervention and exercise programs improved significantly in muscle strength compared with patients who underwent lumbar fusion or placebo. (Keller, 2004) (Storheim, 2003) (Schonstein, 2003) Multidisciplinary bio-psychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate in this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed two weeks without demonstrated efficacy (subjective and objective gains). (Lang, 2003) A recent RCT concluded that lumbar fusion failed to show any benefit over cognitive intervention and exercises, for patients with chronic low back pain after previous surgery for disc herniation. (Brox, 2006) Another trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. (The cognitive treatment focused on encouraging increased physical activity.) (Smeets, 2006) For chronic LBP, cognitive intervention may be equivalent to lumbar fusion without the potentially high surgical

complication rates. (Ivar Brox-Spine, 2003) (Fairbank-BMJ, 2005) See also Multi-Disciplinary pain programs in the Pain Chapter.

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 these “at risk” patients should be physical therapy exercise instruction, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after four weeks if lack of progress from PT alone: Initial trial of three to four psychotherapy visits over two weeks or with evidence of objective functional improvement, total of up to six to ten visits over five to six weeks (individual sessions).

The request for treatment provides a clear evidenced based rationale for the requested treatment and follows the ODG Guidelines.

**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**
- 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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**