

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 10/27/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: individual counseling

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

Diplomate, American Board of Pain Medicine

Diplomate, American Board of Psychiatry and Neurology in Psychiatry

Diplomate, American Board of Quality Assurance and Utilization Review

American Society of Addiction Medicine

Health and Human Services certification for outpatient Suboxone detoxification.

REVIEW OUTCOME

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

Denial Upheld

There is insufficient documentation consistent with ODG for "individual counseling" (psychotherapy).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 07/25/08 thru 08/13/08 – Work hardening notes
2. 11/12/08 – M.D.
3. 05/02/09 – M.D.
4. 06/19/09 – L.P.D.
5. 07/13/09 thru 08/10/09 – Healthcare
6. 10/14/09 –
7. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

I have reviewed the records forwarded on the above employee and have answered the questions submitted. It is important to point out that this review is meant to be of

assistance to you in your case evaluation process and in no way is intended to establish a patient/doctor relationship. Furthermore, my opinion does not constitute a recommendation as to specific or administrative functions.

It is unknown why the employee presented to work hardening for interactive group therapy. However notes (licensed professional counselor notes) show that he is responding well to a work hardening program. Most notes are boilerplate checklists, and there are no objective measures.

There was an evaluation from licensed professional counselor June 19, 2009. The employee apparently twisted his back while polishing an airplane. There were multiple unverifiable symptoms. He was taking narcotics and muscle relaxants and antidepressant. Multiple diagnoses were given but no physical examination was done which is not surprising since this is an LPC. Primary diagnoses is a psychologically-based pain disorder. Individual counseling is recommended, but there were no obvious specific goals relative to the specific individual.

An independent examination by Dr. shows significant symptom exaggeration. There was no improvement in functional status with epidural steroid injections, individual counseling, feedback, and work hardening. Treatment was focused on pain complaints. Multiple ***Official Disability Guidelines*** supporting further behavioral treatment were provided. However, no functional improvement was documented in explanation as to why treatment is focused on pain complaints was not provided.

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

Although individual psychotherapy is covered in the ***Official Disability Guidelines***, additional psychotherapy outside of what has already been provided (apparently six sessions) is not supported for this particular person. Also, treatment focused on pain complaints, especially in this context, is likely to reinforce disability status and pain complaints and is not consistent with the ***Official Disability Guidelines***.

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

Official Disability Guidelines pain section

Note: In workers' compensation cases, providers may need to shift focus from a "cure and relieve" strategy to a "functional restoration" paradigm. Too much attention may be focused on the "pain" and not enough on functional restoration and gain that encourages "coping" strategies and the desirable outcome of "working" with pain. Also consider the possibility of patients developing "Wounded Worker Syndrome," a chronic pain condition characterized by failure of an injured worker to respond to conventional healthcare measures, and prolonged disability with continued absence from the workplace. The main contributor of this condition may be the healthcare system itself, which reinforces the "sickness" role of the injured worker and provides many misguided interventions due to a lack of adequate assessment of underlying psychosocial factors. (Nemeth, 2005)

American Psychiatric Association treatment guidelines for depression

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)

RELATIVE TO PAIN COMPLAINTS (ODG):

Behavioral interventions (from pain treatment section of ODG)

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 <low_back.htm>, "Behavioral treatment", and the Stress/Mental Chapter <stress.htm>.

Functional improvement measures Recommended. Restoration of function should be the primary measure of treatment success. Functional improvement measures should be used over the course of treatment to demonstrate progress in return to functionality, and to justify further use of ongoing treatment methods. They should include the following categories:

Work Functions and/or Activities of Daily Living, Self Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, return-to-work, etc.)

Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits)

Approach to Self-Care and Education (e.g., reduced reliance on other treatments, modalities, or medications, such as reduced use of painkillers) See the Pain Chapter <pain.htm> for more information and references.

Behavioral treatment Low Back 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. (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 biopsychosocial 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 on 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 2 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 <fusion.htm>) 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 <fusion.htm>) (Fairbank-BMJ, 2005) See also Multi-disciplinary pain programs in the Pain Chapter <pain.htm>.

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 4 weeks if lack of progress from PT alone:

Initial trial of 3 psychotherapy visits over 3 weeks

With evidence of objective functional improvement, total of up to 5-6 visits over 5-6 weeks (individual sessions)

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)