



Notice of Independent Review Decision

DATE OF REVIEW: 10/01/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Four 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.

FOUR SESSION OF INDIVIDUAL PSYCHOTHERAPY - OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Behavioral Evaluation and Updated Request for Services, Ph.D., 06/22/09, 08/17/09

- Pre-Authorization Intake Form, 08/21/09, 08/31/09
- Denial Letter, 08/27/09, 09/08/09
- Request for Reconsideration, 08/31/09
- Request for Medical Dispute Resolution, 09/14/09
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient slipped on a pole used to guide cars, resulting in an injury to her right foot. She underwent several levels of treatment, including x-rays, MRI's, physical therapy, TENS unit, and medications. Since the injury, her psychophysiological condition had been preventing her from acquiring the level of stability needed to adjust to her injury, manage the pain and improve her level of functioning.

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

The 4 requested sessions of individual psychotherapy are medically reasonable and necessary.

The request for treatment provides a clear, evidenced based rationale for this treatment and follows the ODG guidelines. This documentation clearly demonstrates the need for the recommended psychological intervention. The patient is clearly experiencing injury related depression, anxiety, insomnia and psychological sequelae as well as chronic pain and the guidelines are clear concerning the recommendation for psychotherapy (see complete guidelines listed below).

The treatment request was denied citing that the request is not consistent with ODG and ACOEM Guidelines concerning the use of individual psychotherapy with this type of patient who is reporting chronic pain. He cites the ODG guideline concerning "consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical therapy alone." I feel this is an incorrect reference from the ODG section concerning low back pain. 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). The patient does not have low back pain.

The documentation as stated that treatment is not appropriate because “the evaluation implies a pain disorder.” It cites that “cognitive therapy for depression or anxiety is only appropriate when it is the primary focus of treatment, which is not the case with this patient who is reporting chronic pain.” It’s suggested that because the patient is diagnosed with a pain disorder that this somehow negates that the primary focus of treatment includes depression and anxiety. The DSM-IV-TR specifically cites that an adjustment disorder may be caused by a disabling general medical condition. The goals for the treatment of the patient’s injury related depression and anxiety were clearly spelled out and are the primary focus of treatment in addition to pain management. The documentation cites ACOEM guidelines which are in direct contradiction to current ODG guidelines concerning the appropriate treatment of patients with chronic pain. Referenced is ACOEM guidelines stating “There is no known effective psychotherapeutic treatment for such disorders (somatoform, mood, or anxiety disorders), per se, when the etiology of symptoms involves a chronic benign pain syndrome.” There is no reference the multiple references from the ODG concerning pain and the treatment of injury related depression, anxiety and insomnia as noted below which demonstrate an abundance of literature concerning the effective use of psychotherapy in the treatment of patients with chronic pain. In the request for reconsideration, Dr. correctly notes that the denial “predominantly cites ACOEM guidelines in an attempt to justify rationale while failing to correctly apply Official Disability Guidelines as mandated by TDI.” The denial also notes that the treatment goals are not “individualized” due to an incorrect use of gender in the report. I would opine that for this to be cited as a typo as a rationale for denial suggests a biased negative evaluation without full consideration of the pertinent documentation supporting the need for treatment.

The second review simply reiterates the denial with the exact same rational and the same OCOEM cite without notation of the ODG cites which support the request for individual psychotherapy. Also disputed is the diagnosis of adjustment disorder stating that “the evaluation repeatedly indicates the patient is suffering with chronic pain and attributes affective disturbance to the injury and pain.” The DSM-IV-TR specifically cites that an adjustment disorder may be caused by a disabling general medical condition. “By definition, an adjustment disorder must resolve within 6 months of the termination of the stressor (or its consequences). However, the symptoms may persist for a prolonged period (i.e., longer than 6 months) if they occur in response to a chronic stressor (e.g., a chronic disabling general medical condition) (DSM IV-TR. Pp. 679).

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 percent relapse rate with antidepressants versus 25 percent 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 6 visits over 6 weeks. With evidence of objective functional improvement, total of up to 13-20 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 6 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 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](#)).

ODG Recommend that treatment for insomnia be based on the etiology. Insomnia: Definition: Secondary insomnia (comorbid insomnia): insomnia that is secondary to other medical and psychiatric illnesses, medications, or sleep disorders. Examples include chronic pain, gastroesophageal reflux disease (GERD), heart failure, end-stage renal disease, diabetes, neurologic problems, psychiatric disorders, and certain medications.

Psychiatric disorders associated with insomnia include depression, anxiety and alcoholism. ([Reeder, 2007](#)) ([Benca, 2005](#)) See [Insomnia treatment](#). See also [Sleep studies](#). Secondary insomnia may be treated with pharmacological and/or psychological measures. Non-pharmacologic treatment: Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. Treatments that are thought to probably be efficacious include sleep restriction, biofeedback, and multifaceted cognitive behavioral therapy. Suggestions for improved sleep hygiene: (a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping. ([Benca, 2005](#)) In a head-to-head comparison of treatment approaches to determine separate and combined effects on insomnia, adding a prescription sleeping pill to cognitive behavioral therapy (CBT) appeared to be the optimal initial treatment approach in patients with persistent insomnia, but after 6 weeks, tapering the medication and continuing with CBT alone produced the best long-term outcome. These results suggest that there is a modest short-term added value to starting therapy with CBT plus a medication, especially with respect to total sleep gained, but that this added value does not persist. In terms of first-line therapy, for acute insomnia lasting less than 6 months, medication is probably the best treatment approach, but for chronic insomnia, a combined approach might give the best of both worlds; however, after a few weeks, the recommendation is to discontinue the medication and continue with CBT. Prescribing medication indefinitely will not work. The authors said that the conclusion that patients do better in the long term if medication is stopped after 6 weeks and only CBT is continued during an additional 6-month period is an important new finding. ([Morin, 2009](#)).

All of the ODG documentation provided supports the treatment request.

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)**