



DATE OF REVIEW: August 18, 2010

IRO Case #:

**Description of the services in dispute:** Six sessions of individual psychotherapy (#90806) and six sessions of biofeedback training (#90901)

**A description of the qualifications for each physician or other health care provider who reviewed the decision**

The clinician who provided this review is a licensed Psychologist in two states. This reviewer is a diplomate in Clinical Neuropsychology, by the American Board of Professional Neuropsychology. This reviewer is a member of the American Psychological Association, the American Pain Society and the National Academy of Neuropsychology. The reviewer has served as the Chief of Neuropsychology and Rehabilitation Psychology at a university medical center, an assistant professor of Psychology, Director of a Children's Rehabilitation Program and staff Psychologist. The reviewer is currently in private practice where has nearly 30 years of experience.

**Review Outcome**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be overturned. Six sessions of individual psychotherapy (#90806) and six sessions of biofeedback training (#90901) are medically necessary.

**Information provided to the IRO for review**

Received from the State 08/02/10:

- Confirmation of Receipt of a Request for a Review by an Independent Review Organization, 07/29/10 – 5 pages.
- Request for Review by an Independent Review Organization, 07/22/10 – 3 pages.
- Utilization Review, 07/07/10 – 2 pages.
- Utilization Review, 06/08/10 – 2 pages.

Records from the Provider 08/03/10:

- Letter from to Medical Review Institute of American, 08/03/10 – 1 page.
- Reconsideration: Behavioral Health Preauthorization Request, 06/30/10 – 3 pages.
- Environmental Intervention Report, 06/07/10 – 1 page.
- Behavioral Health Preauthorization Request, 06/03/10 – 1 page.
- Psychological Testing Results, 05/19/10 – 3 pages.
- Physical Therapy Progress Notes, 05/19/10 – 1 page.
- Physical Therapy Progress Notes, 05/11/10 – 1 page.
- Patient Face Sheet, 05/05/10 – 1 page.

- MRI Cervical Spine, 04/29/10 – 2 pages.
- Physical Therapy Evaluation, 04/27/10 – 1 page.
- History and Physical, 04/23/10 – 4 pages.
- Initial Behavioral Medicine Consultation, 05/04/10 – 5 pages.
- Prescription for Physical Therapy, Psychological Testing, and Individual Counseling, 04/23/10 – 1 page.

Received from Utilization Review Agent 08/04/10:

- Letter from to Medical Review Institute of American, 08/03/10 – 1 page.
- Independent Review Organization Summary, 08/03/10 – 2 pages.
- Official Disability Guidelines/ACOEM: Biofeedback – 7 pages.
- Texas Workers' Compensation Work Status Report, 07/16/10 – 1 page.
- Environmental Intervention Report, 07/07/10 – 1 page.
- History and Physical, 06/30/10 – 4 pages.
- Emergency Department Records, 06/26/10 – 25 pages.
- Case Consultation Note, 06/16/10 – 2 pages.
- History and Physical, 06/16/10 – 1 page.
- Texas Workers' Compensation Work Status Report, 06/15/10 – 1 page.
- Notice of Disputed Issue(s) and Refusal to Pay Benefits, 05/26/10 – 1 page.
- Peer Review by, MD, 05/20/10 – 13 pages.
- Patient Activity Flow Sheet, 05/11/10–05/19/10 – 2 pages.
- Physical Therapy Reevaluation, 05/19/10 – 1 page.
- Environmental Intervention Report, 05/12/10 – 1 page.
- Initial Behavioral Medicine Consultation, 05/04/10 – 5 pages.
- MRI Cervical Spine, 04/29/10 0 2 pages.
- Texas Workers' Compensation Work Status Report, 04/23/10 – 1 page.
- Prescription for Physical Therapy, Psychological Testing, and Individual Counseling, 04/23/10 – 1 page.
- History and Physical, 04/23/10 – 4 pages.
- Request for Medical Records, 04/23/10 – 1 page.
- Texas Workers' Compensation Work Status Report, 04/08/10 – 1 page.
- Occupational Medicine Initial Visit, 04/08/10 – 2 pages.
- Employer's First Report of Injury or Illness, 04/07/10 – 1 page.
- Associate Statement – Workers Compensation, 04/07/10 – 2 pages.
- Associate Incident Log Form, 04/03/10 – 1 page.
- Job Offer – Temporary Alternative Duty, 04/08/10 – 2 pages.
- Thoracic Spine X-rays, 04/05/10 – 1 page.
- Emergency Department Records, 04/05/10 – 10 pages.
- Emergency Department Records, 12/17/09–12/18/09 – 4 pages.
- Emergency Department Records, 08/27/09 – 2 pages.
- Respiratory Patient Assessment, 08/27/09 – 1 page.
- Emergency Department Records, 04/30/09–05/01/09 – 12 pages.

- Emergency Department Records, 10/14/08 - 12 pages.
- Emergency Department Records, 09/13/08 - 10 pages.
- Emergency Department Records, 08/05/08 - 12 pages.
- Emergency Department Records, 07/07/08 - 14 pages.
- Emergency Department Records, 05/08/08-05/09/08 - 10 pages.
- Emergency Department Records, 08/27/09 - 2 pages.
- Pelvic Sonogram, 03/21/08 - 1 page.
- Abdomen Sonogram, 03/21/08 - 1 page.
- Clinic Visit, 03/21/08 - 1 page.
- Emergency Department Records, 03/04/08 - 14 pages.
- Emergency Department Records, 01/22/08 - 11 pages.
- Emergency Department Records, 01/18/08 - 12 pages.
- Emergency Department Records, 05/30/07 - 10 pages.
- Emergency Department Records, 05/22/07 - 11 pages.
- Emergency Department Records, 01/13/07 - 12 pages.
- Emergency Department Records, 12/15/06 - 10 pages.
- Emergency Department Records, 04/02/06 - 6 pages.
- Emergency Department Records, 01/23/04- 7 pages.
- Emergency Department Records, 07/10/02 - 7 pages.
- Emergency Department Records, 06/21/02 - 5 pages.
- Emergency Department Records, 02/13/02 - 5 pages.
- United Regional Emergency Department Records, 01/31/02 - 5 pages.
- Emergency Department Records, 11/14/01 - 3 pages.
- Emergency Department Records, 03/21/01- 5 pages.
- Emergency Department Records, 03/29/00- 3 pages.
- Emergency Department Records, 01/03/00 - 3 pages.
- Emergency Department Records, 01/21/99 - 4 pages.

### **Patient clinical history [summary]**

The date of industrial injury was listed as xx/xx/xx. It was reported that on this date the claimant was working and was injured lifting a large bag of dog food weighing approximately 40-50 pounds. She felt a pop and burning sensation with the acute onset of pain in her neck and back. An Initial Behavioral Medicine Consultation was completed on 05/04/10. It was reported that the claimant was referred by Dr. to Injury1 to evaluate her psychological issues and develop a treatment plan. The patient's treatment to date included medical diagnostic evaluation, medication treatment, and a PT evaluation. Findings reported included evidence of abnormal ambulation, tangential thought processes, dysthymia, and anxious mood. Self-reported information included evidence of extreme irritability, pain, frustration, anger, muscle tension, nervousness, worry, sadness, depression, sleep disturbance, and forgetfulness. It was also noted that pre-existing psychological problems with anger management and anxiety were reported. A previous prescription for Xanax was reported for treatment of anxiety. A psychological evaluation utilizing validated testing was requested. Mild depression and moderate anxiety were reported utilizing self-report inventories (BAI/BDI).

Formal psychological testing was completed on 05/19/10. This evaluation included administration of the Behavioral Medicine Diagnostic (MBMD) and Multiphasic Personality Inventory. Both of these psychological tests are well-known and well-validated inventories. It was not possible to independently validate comments made regarding these inventories since sufficient information (e.g. T-Scores) were not provided for review. The provider reported that the MBMD provided information supporting a finding of significant distress with somatic sensitivity. Validity was not reported.

The provider reported that the findings associated with the MMPI-2-RF included no evidence of over reporting. It was also reported that evidence of somatic preoccupation, sleep disturbance, anergia, and sexual dysfunction were present. Insufficient information (e.g. T-Scores) was provided to allow independent verification of the presence of these psychological findings.

After completing psychological testing, a clinical diagnosis of pain disorder with associated psychological factors was noted. It was also noted that the psychological test results provided evidence that the claimant required psychological treatment in the form of individual psychotherapy along with biofeedback to treat her refractory pain.

A request was submitted for six sessions of individual psychotherapy and six sessions of biofeedback treatment. Submitted documentation indicated that an initial review was completed by Dr. with Dr., both clinical psychologists. Dr. denied the requested care. Submitted documentation indicated that the subsequent reconsideration/appeal was completed by, MD. Dr.'s specialty is Occupational Medicine. Dr. also issued an adverse decision.

Dr. issued an adverse decision with a rationale that the patient's presentation was inconsistent, commenting on her tangential thinking and inconsistencies in testing. Dr. issued an adverse decision based on a pre-existing prescription for Xanax.

**Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.**

The original adverse decision regarding six sessions of individual psychotherapy and six sessions of biofeedback treatment should be reversed. Sufficient psychological information was provided to support the clinical necessity of both the individual psychotherapy and biofeedback treatment. Apparently, on appeal the reviewer denied the clinical necessity of the requested services based on information that the claimant was taking Xanax before sustaining an industrial injury. However, while the claimant may have suffered from anxiety prior to this injury, sufficient information was provided to establish that her psychological condition was exacerbated by the industrial injury. Biofeedback treatment is an excellent clinical resource for the treatment of anxiety and associated muscle tension. Biofeedback will not be a stand-alone treatment. The request for individual psychotherapy and biofeedback treatment is medically necessary.

After reviewing a request for reconsideration for six sessions of individual psychotherapy and six

sessions of biofeedback, the six sessions of individual psychotherapy and six sessions of biofeedback are medically necessary.

**A description and the source of the screening criteria or other clinical basis used to make the decision:**

CBT/Psychotherapy:

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)

ODG: Biofeedback Guidelines:

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