

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 4, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed 6 sessions of biofeedback (90901) and 6 sessions of Individual 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)
 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
836.1	90806		Prosp	6					Overturn
836.1	90901		Prosp	6					Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-21

Respondent records- a total of 46 pages of records received to include but not limited to: TDI letter 7.15.10; PHMO letter 7.15.10; TPA for 6.1.10, 6.28.10; MRI Cervical spine 9.23.09; MRI left knee 12.14.09; Diagnostics 12.16.09; Injury Clinic 12.22.09-6.22.10 ; Pain Associates records 1.5.10, 1.20.10; Dr. records 1.28.10, Inc report 3.24.10;

Requestor records- a total of 40 pages of records received to include but not limited to: Injury Clinic records 12.22.09-7.15.10; TDI letter 7.15.10; request for an IRO forms; TPA for 6.1.10-6.28.10; MRI knee 12.14.09; MRI C-spine 9.23.09; Diagnostics 12.16.09; Dr. report 5.13.10

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured at work on xx/xx/xx. At the time of the injury, she was performing her usual job duties when she sustained injuries to her right shoulder, cervical spine, and left knee after slipping and falling backwards on a wet floor. Patient sought treatment on

9/2/9 when her symptoms continued to worsen. MRI revealed disc bulge at C5-6 and flattening of the cervical cord. MRI of the left knee revealed posterior horn lateral meniscus tear and complete avulsion of the anterior horn lateral meniscus. Patient completed 2 months of PT. Patient continues with severe pain reports and observed distress. She has medication management to include Darvocet, Lyrica, and Flexeril. She is currently diagnosed with cervical and right shoulder strain/sprain, S/P knee surgery, major depressive disorder, and bilateral cervical radiculopathy.

Treating physician referred the patient for a psychological evaluation to assess appropriateness for continued conservative individual therapy sessions. Individual therapy was approved and patient has attended 6 sessions. Patient was able to reduce pain, irritability, frustration, nervousness, and sleep problems by 10% with a 20% reduction in self-reported depressive symptoms. Current request is for additional 6 IT sessions combined with biofeedback. Plan is to use cognitive-behavioral and relaxation therapies to decrease initial and sleep maintenance insomnia to 8 hours per night, decrease the patient's anxious/depressed symptoms, and decrease reported pain perception by 60%.

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/GUIDLINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

A diagnostic interview with mental status, testing and recommendations was requested by the patient's treating doctor, and has been conducted. The results indicated that patient could benefit from cognitive-behavioral and relaxation interventions aimed at improving coping skills in order to reduce injury-related pain, irritable/anxious mood, psychosocial issues, and any associated fears. A stepped-care approach to treatment has been followed, as per ODG, and the patient has made progress overall. Requested continued sessions therefore meet ODG criteria, as does the biofeedback since it will be incorporated into a cognitive-behavioral program. The request is considered medically reasonable and necessary at this time.

ODG Work Loss Data, 2010 online, Texas

<p>Psychotherapy for MDD (major depressive disorder)</p>	<p>Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. (American Psychiatric Association, 2006) See also Cognitive therapy for additional information and references, including specific ODG Psychotherapy Guidelines (number and timing of visits).</p> <p><i>Patient selection.</i> Standards call for psychotherapy to be given special consideration <i>if</i> the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans which did not involve psychotherapy.</p> <p><i>Types of psychotherapy.</i> The American Psychiatric Association has published the following considerations regarding the various types of psychotherapy for MDD:</p> <ul style="list-style-type: none"> - Cognitive behavioral psychotherapy is preferable to other forms of psychotherapy, because of a richer base of outcome studies to support its use, and because its structured and tangible nature provides a means of monitoring compliance and progress. - In contrast, psychodynamic psychotherapy is not recommended because
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	it has specifically been identified as lacking scientific support, and is severely vulnerable to abuse because it can involve a lack of structure. (American Psychiatric Association, 2006)
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Cognitive therapy for depression	<p>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)</p> <p>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)</p>
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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

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

Biopsychosocial model of chronic pain; ODG Pain section, 2009: See [Chronic pain programs](#) (functional restoration programs), which are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of [delayed recovery](#), including the detailed "Criteria for use of multidisciplinary pain management programs" highlighted in blue. *Definition:* The biopsychosocial model, first proposed by George Engel, MD, acknowledges the important interplay between the biological, psychological, and social systems in illness. While disease is defined as the objective effect of pathology, illness includes the patient's perception of lack of health. An exclusively biomedical focus on objective pathology and disease is of limited usefulness in conditions like chronic pain. A focus on the patient's illness, which includes his or her psychological reactions and social function, may lead to more effective involvement in treatment, with diminished disability, improved function, and diminished co-morbidity. The model focuses on disease and illness, with illness being viewed as an interaction of biological (physiological), psychological and social factors. Disease is defined as the objective event that involves the actual pathology. Pain is experience as a unique experience, and a range of psychological and socioeconomic factors can modulate physical pathology to affect symptoms and subsequent disability. The model is utilized in interdisciplinary pain clinics as patients with chronic pain are at increased risk for emotional disorders, maladaptive cognitions, functional deficits, nociceptive dysregulation, and physical deconditioning. See also [Psychosocial adjunctive methods](#) in the Mental Illness & Stress Chapter.

Delayed Recovery (2009). Recommend evidence-based treatments for patients with conditions that have resulted in delayed recovery. Identification of delayed recovery is dependent on the specific injury or illness, and disability duration guidelines can provide guidance. Two approaches have been suggested:

(1) *At-Risk cases:* Disability duration experience data, for each condition, can show expected calendar-days away from work by decile, using the 50% number for “Midrange” and the 90% number for “At-Risk”. The At-Risk number of days may be used to trigger “Delayed recovery” interventions, because it is the point at which 90% of cases with this primary diagnosis should have returned to work, and the point when the case has already become an outlier and is at risk of never returning to functionality. ([ODG Help, 2009](#)) To identify these “At-Risk” cases, see the appropriate RTW guidelines by [ICD9 diagnosis code](#). For example, for lumbar sprains and strains ([ICD9 847.2](#)), the At-Risk time using claims data would be 63 days. For lumbar disc disorders ([ICD9 722.1](#)), it would be 144 days.

(2) *30 days beyond normal healing:* The Treatment Planning section of this chapter defines chronic pain as pain that persists for at least 30 days beyond the usual course of an illness, so

that Delayed recovery would include cases taking longer than this. ([ODG TP, 2009](#)) The normal course of recovery can be identified from experience data in the appropriate RTW guidelines by [ICD9 diagnosis code](#). For example, for lumbar sprains and strains ([ICD9 847.2](#)), the expected Midrange (median) time using claims data would be 17 days, so Delayed recovery would start at 47 days, using this approach. For lumbar disc disorders ([ICD9 722.1](#)), it would be 96 days (66 plus 30).

See also [Chronic pain programs](#) (functional restoration programs).

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)