CLAIMS EVAL

Utilization Review and Peer Review Services

URAC ACCREDITED

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 8-2-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Individual psychotherapy 1 x 6, biofeedback 1 x 6 CPT 90806, 90801

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

- 12-23-09 MRI of the lumbar spine.
- 12-23-09 MRI of the right shoulder.
- 1-26-10 MRI of the cervical spine.
- 2-3-10 MRI of the thoracic spine.
- 5-5-10 MS, LPC., Initial Behavioral Medicine Consultation.
- 6-10-10 MS, LP., office visit.
- 6-16-10 MD., Independent medical evaluation.

- 6-18-10 PhD., performed a utilization Review.
- 7-15-10 PhD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

12-23-09 MRI of the lumbar spine shows degenerative disc disease and facet disease at L3-L4 and L4-L5 with mild to moderate L3-L4 and mild L4-L5 canal stenosis. Incompletely evaluated degenerative disc changes at T10-T11. No pathologic enhancement to suggest regional metastatic disease.

12-23-09 MRI of the right shoulder shows moderate supraspinatus tendinopathy. Very small partial tears present involving the supraspinatus and infraspinatus tendons. There is a superior labral tear. There is mild intra articular biceps tendinopathy.

1-26-10 MRI of the cervical spine shows multilevel degenerative disc disease and spondylosis that is most prominent at the C5-C6. There is no abnormal cord intrinsic cord signal intensity. There are no abnormal enhancing lesions. There is no evidence of significant neural foraminal stenosis.

2-3-10 MRI of the thoracic spine shows multilevel degenerative changes without radiographically significant compromise of the central canal or foramina.

5-5-10 MS, LPC., Initial Behavioral Medicine Consultation. The claimant was referred for a behavioral health consultation at the directive of her treating physician, D.O. He requested we evaluate Ms. to determine her treatment needs. He specifically asked that we evaluate her emotional status and subjective pain to assess the relationship to the work accident and to determine her suitability for progression to some sort of low-level behavioral treatment. The claimant states that she sustained a work related injury to her cervical spine, thoracic spine, lumbar spine, right shoulder, and right arm on xx/xx/xx while performing her customary duties as a (RN) for. Per report, she was employed by the company for x year and xx months at the time of the injury. She states that she was moving a container of baby replicas to the back of the building for storage. The incident was reported on the date of injury. She first sought treatment with the company doctor on the date of injury and received an injection for pain, her arm was put in a sling, and a prescription for pain medication. On 12/23/09 an MRI of the lumbar spine without and with contrast showed degenerative disk and facet disease at L3-4 and L4-5 with mild to moderate L3-4 and mild L4-5 canal stenosis. On 12/23/09 a MRI of the right shoulder showed moderate supraspinatus tendinopathy, very small partial tears present involving the supraspinatus and infraspinatus tendons, superior labral tear, and mild intra-articular biceps tendinopathy. On 01/26/10 a MRI of the cervical spine with and without contrast indicating multilevel degenerative disk disease and spondylosis that is most prominent at C5-6. An MRI of the thoracic spine without and with contrast on 02/03/10 revealed multilevel degenerative changes without radiographically significant compromise of the central canal or foramina. Per report, she has received 2 days of physical therapy and 1 trigger-point injection. Her treating doctor, Dr. 0.0., has asked us to assess this patient's suitability for some level of behavioral health care, secondary to severe pain complaints

and observed distress. Present med: Adderall 30 mg per the claimant. Mental status exam: The claimant appeared appropriate for her stated age. She was cooperative throughout the interview. She was oriented times five to date, person, place, situation, and time. Her attention, speech, and psychomotor activity were all deemed to be normal. Her memory for both recent and remote events was intact. Intellectual functioning was within normal limits. Her mood was dysthymic. Pier affect was appropriate to content. Her thought process was goal-directed. Her thought content was positive for ruminations related to her condition. The patient presented no evidence of hallucinations or delusions. Judgment, insight, and impulse control were all deemed to be fair. She does endorse current suicide ideation thoughts, but with no plan. When asked to quantify her symptoms numerically, the patient reveals the following: irritability and restlessness, 8/10; frustration and anger, 7/10; muscular tension/spasm, 8/10; nervousness and worry, 9/10; sadness and depression, 8/10; sleep disturbance, 9/10; and forgetfulness and poor concentration, 8/10. Based upon the information gathered through the clinical interview, mental status exam, behavioral observations, patient symptom rating scale, and pain drawing, the following is a multiaxial diagnosis: Axis I: 307.89 Pain Disorder associated with both psychological factors and a general medical condition, Chronic, secondary to the work injury. Axis II: V71.09, no diagnosis. Axis III: Injury to cervical spine, thoracic spine, lumbar spine, right shoulder, and right arm. Axis IV: Primary support group, Economic, and Occupational issues. Axis V: GAF = 60 (current). Estimated pre-injury GAF = 85+. The initial evaluation that was completed in the office suggests that Ms. would greatly benefit from a brief course of individual psychotherapeutic intervention to facilitate a healthy adjustment and improve her coping with her physical work injury and pain problem of xx/xx/xx. This should assist her in developing tools and skills for the management of her injury-related distress. The patient should receive immediate authorization for participation in a brief low level of individual psychotherapy for 4 weeks. They will work to reduce disturbances in mood and resolve psychosocial stressors by providing the appropriate community resource referrals. We expect that this level of treatment will create a very positive response in her physical rehabilitation program and accelerate her recovery while simultaneously resolving psychosocial stressors and developing a plan to expedite her return to normal functioning. Should her function fail to improve and mood symptoms fail to abate, she may be a highly suitable candidate for a comprehensive rehabilitation program.

6-10-10 MS, LP., Diagnosis: Axis I: 307.89 Pain Disorder Associated with both psychological factors and a general medical condition, Chronic, secondary to the work injury. 296.23 Major Depressive Disorder, single episode, severe without psychotic features Axis II: V71.09 No diagnosis. Axis III: Injury to back — see medical records Axis IV: Primary support group, occupational, economic. Axis V: GAF 59 (current) Estimated Pre-injury GAF = 85+. The evaluator reported that during the course of her four 1PT sessions. The claimant has become increasingly frustrated with her severe pain and lack of physical functioning. She regularly expresses her desire to heal and recover that she may return to working. The claimant has been active throughout the course of her life and she has healed from injuries in the past. Therefore, the severity of these injuries and slow rate of recovery is particularly frustrating to her. The claimant has been very active in her treatment processes. She seems to have responded

especially well to CBT; most particularly with identifying anxiety triggers, challenging negative automatic thoughts, and understanding the stress-pain appraisal connection. The claimant shows positive responses to progressive relaxation and guided imagery exercises. In conjunction with the relaxation training, the claimant has practiced deep abdominal breathing and she has implemented a daily practice of 8 minute breathing sessions, 3-4 times daily. This has benefited the claimant in session by reducing pain, anxiety, tension, and frustration. While the claimant has implemented these exercises into a regular routine at home, she has difficulty doing them on her own. Thus the claimant needs additional visual and auditory feedback help to improve her self regulation. In addition to the psychological progress that the claimant has accomplished, she has also made functional physical progress as well. She has increased her strength and endurance to the point that she is capable of moving around her house. This has allowed her to attempt activities of daily living such as light cooking, self grooming, light cleaning, dressing, etc. This increase in mobility and tolerance for pain has somewhat improved Ms social life. She has been more open to communication with friends and family as she feels that she has more to contribute. Although she has improved, the claimant continues to have difficulty with activities of daily living such as standing for more than 10 min, bending, walking balance, etc. The claimant reports positive psychological improvement on most of the self report measures. The continuation of severe levels of distress can be accounted for by financial difficulties, limited mobility, and diminished social networks. In addition to the Beck's inventories and the VAS instrument, the claimant completed the Fear Avoidance Beliefs Questionnaire (FAN)). What the FABQ revealed was that the claimant endorses the fear avoidance scale for both physical activity and work. This indicates that the claimant may need additional aide confronting her pain. As the claimant still presents with severe negative psychological symptoms, she is therefore recommended for additional treatment. In order to reach treatment objectives, 6 more sessions of IPT, and 6 sessions of biofeedback therapy are being requested at this time. Past sessions have focused on identification of stressors, education regarding stress relief and relaxation, and introduction of various coping strategies. Future sessions will focus on seg-acceptance, implementation of coping strategies, and adaptation to physical gains as well as limitations. In addition, formal biofeedback therapy will expedite the entrainment of these relaxation skills. Use of visual and auditory feedback mechanisms will aide her generalization for relaxation skills across environments.

6-16-10, MD., the claimant was seen for an Independent medical evaluation. He noted the claimant has a diagnosis of a tear of the rotator cuff of the right shoulder with ongoing pain. In regards' to her thoracic and lumbar spine, she has degenerative changes. The evaluator found no acute changes and he believed she just has a lighting up of her underlying degenerative arthritic condition. Distal circulation, arms and legs, was intact. It was his opinion, the examinee sustained a lumbar strain that should more or less be resolved, but she continues to complain of some residual aches and pains due to lighting up of her underlying degenerative condition. I would expect that ongoing treatment of the low back should be finished and she could be managed with over-the-counter anti-inflammatory medication. With regards to her shoulder, she has a tear of the rotator cuff with appropriate findings now of impingement and some weakness. She

did not appear to be magnifying her symptoms. She needs a right shoulder arthroscopy and repair of the rotator cuff. She will need office visits for maintenance of medications and office visits following surgery. The examinee is taking Lyrica, which is appropriate because she does complain of some neuritic pain. The Hydrocodone is used as needed. The Flector patch is used for her shoulder. She is taking Tizanidine as a muscle relaxant. Also, she takes Tramadol for milder pain. These medications are appropriate and within the ODG. She lists the other medicines she is taking at this time for hypertension, which is not related. Also, she takes a Lidoderm patch to the low back. She could be managed with over-the-counter anti-inflammatory medication for the low back. In summary, surgery is indicated for this individual. The use of Lyrica, Hydrocodone, Flector Patch, Tramadol and Flexeril are indicated. The other medications are not indicated. At this point in time, based on the ODG criteria, the evaluator would recommend that the examinee have a right shoulder arthroscopy and repair of the rotator cliff. The MRI of her right shoulder reveals a small partial tear of the supraspinatus, as well as the infraspinatus. There is questionable labral tear and there is some tendinopathy. Dr. did perform injections of her shoulder. Current pain complaints are rated 4 to 6/10 with difficulty sleeping secondary to pain. On exam, she has pain over the glenohumeral articulation with a positive impingement test. She has give-way weakness when tested in abduction and in flexion. A right shoulder arthroscopy and repair of the rotator cuff is reasonable and necessary. Additional physical therapy, work hardening, work conditioning, diagnostic testing, injections, durable medical equipment or chiropractic manipulations are not reasonable or necessary. Her injury occurred on. At this point in time, he would expect that ongoing treatment of the low back should be completed and could be managed with over-the-counter anti-inflammatory medication; however, she does need a surgical intervention for her shoulder. Psychological testing is not reasonable or necessary. The examinee did not appear to be depressed. She brings in photos showing that she was relatively active before this injury, and her aim for recovery is to return to the same level of activity. She feels that if she can have her shoulder somewhat improved, she could go back to swimming which she feels would help rehabilitate her back. A chronic pain management program is not reasonable or necessary at this time.

6-18-10 PhD., performed a Utilization Review. The evaluator reported he discussed this case and requested procedure with Dr.. The clinical indication and necessity of these procedures could not be established. The mental health report of 5/10 notes impressions of pain disorder and major depressive disorder. When the patient was evaluated on 5/5/10, she was not using the above medications, by report. In addition, the diagnosis of major depressive disorder has been added, without any clinical rationale. Although there has been some progress in self-care and ADL in the 'period' (see below) of psychotherapy treatment, there is no demonstration that this is due to the counseling as opposed to the exercise program and to the medication regimen, which are more likely. In addition, it is noted, per the record, that four treatments were provided between the above two dates (5 days apart), which seems unlikely. The requested biofeedback is not reasonable and necessary. There are no controlled studies, randomized clinical trials, or evidence based guidelines supporting the use of

biofeedback techniques, either unimodally or in combination with psychotherapy, in producing objective functional improvements with this type of chronic benign musculoskeletal pain condition. Since there is no demonstration of a further need for continuing the psychotherapy, adjunct biofeedback is not indicated. Moreover, induction of general relaxation states is a common technique in psychotherapeutic treatment. However, there is no empirical evidence that biofeedback procedures are more effective than clinician induced methods in this regard; and biofeedback is not approved as a separate procedure for this purpose. There is no quality evidence to support biofeedback therapy for the proposed 'control of anxiety and muscle tension"; and there are no empirical data to support a role of 'muscle tension' in this type of chronic benign pain presentation. I am not able to establish a basis that these treatments are both reasonable and necessary at this time. Non-approval is recommended.

7-15-10, PhD., performed a Utilization Review. The initial review cites several deficiencies in the initial request for services. The issues raised by the initial reviewer were not addressed. There was no additional documentation provided that would impact the prior recommendation for nonauthorization. The patient has completed 4 sessions of individual psychotherapy. The request is inconsistent with ODG which states that additional psychological treatments should only be provided 'with evidence of objective functional improvement' from previous psychological treatments. A brief treatment update on 06/10/10 provides minimal data concerning the patient's response to these sessions and no objective functional improvement is reported. There has been no change in the severity if the patient's psychological symptoms (Beck scores), the patient has not returned to work and no return to work plan is provided. Furthermore, this is an injury and evaluation diagnoses a Pain Disorder. 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. This request is not consistent with ODG concerning the use of individual psychotherapy with this type of patient who is reporting chronic pain, ODG (for chronic pain and back injuries) states consider separate psychotherapy CBT referral after 4 weeks if lack or progress from PT alone. At the present time there is no concurrent physical therapy treatment of this injury. Since additional individual psychotherapy is not appropriate for this patient, the necessity of biofeedback training could not be established. ODG (for biofeedback training) recommend initial therapy for these 'at risk' patients should be physical therapy and possibly consider biofeedback referral in conjunction with CBI'. Additional CBT is not indicated and there is no concurrent physical therapy of this injury. Guidelines state that biofeedback is not recommended as a stand-alone treatment. These issues indicate that the request is not consistent with the requirement that psychological treatments only be provided for 'an appropriately identified patient. Based on the documentation provided, ODG criteria were not met. It is recommended that the request for additional individual psychotherapy x 6 and biofeedback training is not reasonable or necessary. The evaluator recommends non-approval. The evaluator contacted Dr. who is authorized to discuss this case. Treatment goals, treatment history and the patient's psychological symptoms were discussed. The evaluator recommends an adverse determination.

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

The claimant has an injury date of xx/xx/xx. She has had diagnostics, physical therapy, injections, PT, and IT. She has reportedly not attempted to return to work. According to the available records, this claimant initially reported suicidal ideations, high self-reported psychological distress, and had a BAI of 24 and BAI of 32. She also reportedly demonstrated high fear-avoidance scores. The claimant reportedly participated in 4 IT sessions with CBT and progressive relaxation with guided imagery. While it was noted that she benefited from the sessions, her pain level reportedly did not change, her BAI decreased by only one point, and her BDI decreased by only four points. In addition, she reportedly continued to experience significant fear-avoidance. There is little documentation about a coordinated treatment plan, any decrease in medications, or why she was not able to attempt to return to work. An IME dated 6/16/10 notes that the claimant needs shoulder surgery, is not depressed, and does not need CPMP. There is little documentation overall regarding the claimant's treatment plan, why more progress was not made, and why she has not been able to return to work in eight months. Based on the available information, the necessity for additional IT along with biofeedback does not appear to be reasonable and necessary.

ODG-TWC, last update 7-27-10 Pain – Psychotherapy: 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. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005) See also Psychosocial adjunctive methods in the Mental Illness & Stress Chapter. Several recent

reviews support the assertion of efficacy of cognitive-behavioural therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). (Kröner-Herwig, 2009)

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)**