

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

January 4, 2010  
Amended: January 11, 2010

**DATE OF REVIEW:** JANUARY 4, 2010 AMENDED ON JANUARY 11, 2010

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity of proposed 6 sessions of 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
726.10, 836.0, 724.4, 722.10	90806		Prosp	6					Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-19 pages

Respondent records- a total of 43 pages of records received to include but not limited to:  
TDI letter 12.14.09; Texas Health records 10.14.09-11.9.09; Dr. notes 9.14.09-9.30.09

Requestor records- a total of 32 pages of records received to include but not limited to:  
TDI letter 12.14.09; Texas Health records 9.14.09-12.18.09; Request for an IRO forms; letter  
10.14.09, 11.9.09; Dr. note 9.30.09

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured at work on xx/xx/xx. At the time, she was performing her usual job duties as a, when she was involved in high-speed MVA. Patient was not transported from the scene, but did go to the emergency room herself due to increased severe pain the next day. Patient began care with Dr. and is in the primary stage of treatment.

Records state that x-rays were taken, but were not available for review at the time of the report. Mental status exam states that patient has good recent and remote memory, but then goes on to state that patient is experiencing anterograde amnesia for events immediately preceding the wreck. Patient is reporting 10/10 pain on average to include cervical, base of skull right UE, chest, thoracic, lumbar, and right knee and upper right leg. Only medication reported is HCTZ for hypertension.

On the PSRS, patient rated irritability and restlessness and muscular tension at 9/10. She rated frustration, anger, nervousness, worry, sadness and depression, sleep disturbance and forgetfulness/poor concentration at 10/10. Patient was diagnosed with 309.28 adjustment disorder with anxiety and depressed mood, secondary to the work injury.

The current request is for individual cognitive-behavioral therapy 1x6 with goals of improving mental status and improving sleep.

### **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/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

The goals for treatment discussed above may be appropriate in the future, but currently it appears that the diagnostics needed to further and completely elucidate the problems have not been pursued. Specifically, there is no mention of whether or not patient hit her head during the accident, or whether there was any loss of consciousness, but patient is having problems with memory/concentration, and this needs to be further evaluated by a neurologist and/or neuropsychologist to determine appropriate diagnosis and treatment. Additionally, ODG recommends an anti-depressant in addition to psychotherapy for more severe cases, and patient is reporting a 10/10 depression. Again, patient appears to need a full work-up to rule out possibilities such as post-concussive syndrome, PTSD, closed head injury, etc. This is particularly important since 85% of patients who do not get help with post-concussive symptoms in the first year following injury seem to fare much worse than their counterparts who do receive appropriate medical and behavioral interventions.

The URA's determination that medical necessity could not be established at this time is upheld.  
(See the following from ODG Work Loss Data, 2007):

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**

This comprehensive review shows test name; test characteristics; strengths and weaknesses; plus length, scoring options & test taking time. The following 26 tests are described and evaluated:

- 1) 1) BHI™ 2 (Battery for Health Improvement – 2nd edition)
- 2) 2) MBHI™ (Millon Behavioral Health Inventory)
- 3) 3) MBMD™ (Millon Behavioral Medical Diagnostic)
- 4) 4) PAB (Pain Assessment Battery)
- 5) 5) MCMI-111™ (Millon Clinical Multiaxial Inventory, 3rd edition)
- 6) 6) MMPI-2™ (Minnesota Inventory- 2nd edition™)
- 7) 7) PAI™ (Personality Assessment Inventory)
- 8) 8) BBHI™ 2 (Brief Battery for Health Improvement – 2nd edition)
- 9) 9) MPI (Multidimensional Pain Inventory)
- 10) 10) P-3™ (Pain Patient Profile)
- 11) 11) Pain Presentation Inventory
- 12) 12) PRIME-MD (Primary Care Evaluation for Mental Disorders)
- 13) 13) PHQ (Patient Health Questionnaire)
- 14) 14) SF 36™
- 15) 15) (SIP) Sickness Impact Profile
- 16) 16) BSI® (Brief Symptom Inventory)
- 17) 17) BSI® 18 (Brief Symptom Inventory-18)
- 18) 18) SCL-90-R® (Symptom Checklist –90 Revised)
- 19) 19) BDI®-II (Beck Depression Inventory-2nd edition)
- 20) 20) CES-D (Center for Epidemiological Studies Depression Scale)
- 21) 21) PDS™ (Post Traumatic Stress Diagnostic Scale)
- 22) 22) Zung Depression Inventory
- 23) 23) MPQ (McGill Pain Questionnaire)
- 24) 24) MPQ-SF (McGill Pain Questionnaire – Short Form)
- 25) 25) Oswestry Disability Questionnaire
- 26) 26) Visual Analogue Pain Scale (VAS)

All tests were judged to have acceptable evidence of validity and reliability except as noted. Tests published by major publishers are generally better standardized, and have manuals describing their psychometric characteristics and use. Published tests are also generally more difficult to fake, as access to test materials is restricted to qualified professionals. Third party review (by journal peer review or Buros Institute) supports the credibility of the test. Test norms provide a benchmark to which an individual's score can be compared. Tests with patient norms detect patients who are having unusual psychological reactions, but may overlook psychological conditions common to patients. Community norms are often more sensitive to detecting psychological conditions common to patients, but are also more prone to false positives. Double normed tests (with both patient and community norms) combine the advantages of both methods. Preference should be given to psychological tests designed and normed for the population you need to assess. Psychological tests designed for medical patients often assess syndromes

unique to medical patients, and seek to avoid common pitfalls in the psychological assessment of medical patients. Psychological tests designed for psychiatric patients are generally more difficult to interpret when administered to medical patients, as they tend to assume that all physical symptoms present are psychogenic in nature (i.e. numbness and tingling may be assumed to be a sign of somatization). This increases the risk of false positive psychological findings. Tests sometimes undergo revision and features may change. When a test is updated, the use of the newer version of the test is strongly encouraged. Document developed by, PsyD and accepted after review and revisions by the Chronic Pain Task Force, June 2001. Dr. is the coauthor of the BHI 2 and BBHI 2 tests.

Rating: 7a

**Psychological treatment:** 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](#))

**Behavioral Treatment:** Recommended as option for patients with chronic low back pain and delayed recovery. Also recommended as a component of a Chronic pain program (see the [Pain Chapter](#)). Behavioral treatment, specifically cognitive behavioral therapy (CBT), 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. ([Newton-John, 1995](#)) ([Hasenbring, 1999](#)) ([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](#)) 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](#)) ([Fairbank-BMJ, 2005](#)) See also Multi-disciplinary pain programs in the [Pain Chapter](#).

### **ODG cognitive behavioral therapy (CBT) guidelines for low back problems:**

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See [Fear-avoidance beliefs questionnaire](#) (FABQ).

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 3-4 psychotherapy visits over 2 weeks
- With evidence of objective [functional improvement](#), total of up to 6-10 visits over 5-6 weeks (individual sessions)

MDD treatment, moderate presentations: Recommend options as indicated below. Professional standards call for treatment planning to be based on the severity of the presentation of MDD ([American Psychiatric Association, 2006](#)), but the standards do not provide adequate definitions of what is involved in a moderate or severe presentation. ([American Psychiatric Association, 2000](#)) Subsequently, this discussion will not have the ability to eliminate the confusion that will be caused by attempts to follow professional standards, because confusion is actually inherent to those standards. A “moderate” presentation is defined as falling somewhere between the vague definition of severe presentation (defined as involving most of the diagnostic features for a major depressive episode, and a similarly severe presentation of impairment) and the definition of mild that was discussed above (five to six of the diagnostic features for a major depressive episode, and a similarly mild presentation of impairment). ([American Psychiatric Association, 2000](#))

Treatment options:

**A. Medication:** The American Psychiatric Association strongly recommends anti-depressant medications for moderate presentations of MDD, unless electroconvulsive therapy (ECT) is being planned. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of anti-depressant medications, and those considerations are summarized in the Procedure Summary, [Antidepressants for treatment of MDD](#) (major depressive disorder). ([American Psychiatric Association, 2006](#))

**B. Psychotherapy:** The American Psychiatric Association’s standards note that Cognitive behavioral psychotherapy (CBT) may be considered as a solo initial treatment for moderate presentations of MDD. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of psychotherapy, and those considerations are summarized in the Procedure Summary, [Psychotherapy for MDD](#) (Major Depressive Disorder) - *Patient selection*. ([American Psychiatric Association, 2006](#)) Standards call for psychotherapy to be given special consideration **IF** the claimant is experiencing any of the following: (1) significant stressors; (2) internal conflict; (3) interpersonal difficulties; (4) a personality disorder. ([American Psychiatric Association, 2006](#)) A randomized controlled trial has indicated that the patient’s smoking status is a credible factor that can be considered in the treatment plan. Specifically, anti-depressant medication (fluoxetine/Prozac) has been found to compromise the success of smoking cessation efforts. ([Spring, 2007](#)) Subsequently, if the patient is attempting to quit smoking, that effort is an indication that psychotherapy in the absence of anti-depressant medication might be a more acceptable plan than standards would normally indicate.

**C. Combined use of both psychotherapy and medication:** Practice standards endorse using both treatment options for moderate presentations of MDD which simultaneously involve: (1) social issues/interpersonal problems; (2) a personality disorder; & (3) a history of only partial response to treatment plans which involved only psychotherapy or only medication. ([American Psychiatric Association, 2006](#)) The considerations that were referenced above in regard to psychotherapy and medication options can also be applied to considerations of using both together.

MDD treatment, severe presentations: Recommend options as indicated below. Professional standards call for treatment planning to be based on the severity of the presentation of MDD ([American Psychiatric Association, 2006](#)), but the standards do not provide an adequate definition of what is involved in a severe presentation. ([American Psychiatric Association, 2000](#))

Subsequently, this discussion will not have the ability to eliminate the confusion that will be caused by attempts to follow professional standards. A “severe” manifestation is defined as involving most of the diagnostic features for a major depressive episode, and a similarly severe presentation of impairment. ([American Psychiatric Association, 2000](#)) Treatment options:

A. Medication: The American Psychiatric Association strongly recommends anti-depressant medications for severe presentations of MDD, unless electroconvulsive therapy (ECT) is being planned. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of anti-depressant medications, and those considerations are summarized in the Procedure Summary, [Antidepressants for treatment of MDD](#) (major depressive disorder). ([American Psychiatric Association, 2006](#))

B. Psychotherapy in combination with medication: The American Psychiatric Association's standards note that Cognitive behavioral psychotherapy (CBT) may be considered as part of a combined treatment plan for severe presentations of MDD. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of psychotherapy, and those considerations are summarized in the Procedure Summary, [Psychotherapy for MDD](#) (Major Depressive Disorder) - *Patient selection*. ([American Psychiatric Association, 2006](#)) Standards call for psychotherapy to be given special consideration **IF** the claimant is experiencing any of the following: (1) significant stressors; (2) internal conflict; (3) interpersonal difficulties/social problems; (4) a personality disorder; & (5) a history of limited/partial response to treatment plans which involved only psychotherapy or only medication. ([American Psychiatric Association, 2006](#))

C. Electroconvulsive therapy: The American Psychiatric Association's standards endorse electroconvulsive therapy (ECT) as a treatment option for severe manifestations of MDD, presentations which specifically involve acute suicidality, cases in which nutritional compromise has occurred subsequent to the claimant refusing food, cases which involve catatonia, or cases which involve psychosis (psychotic presentations are discussed individually below). ([American Psychiatric Association, 2006](#))

MDD treatment: Psychotic presentations: Recommend options as indicated below. This diagnostic classification applies to manifestations of MDD that involve active delusions or hallucinations. ([American Psychiatric Association, 2000](#)) Treatment options:

A. Combined use of antipsychotic and antidepressant medications: Professional standards strongly recommend that either this approach, or the following option, should be implemented for psychotic manifestations of MDD. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of anti-depressant medication, and those considerations are summarized in the Procedure Summary, [Antidepressants for treatment of MDD](#) (major depressive disorder). ([American Psychiatric Association, 2006](#))

B. Combined use of antipsychotic medication and electroconvulsive therapy (ECT): Professional standards strongly recommend that either this approach, or the preceding option, should be implemented for psychotic manifestations of MDD. ([American Psychiatric Association, 2006](#)) This option may be preferable to the preceding option for circumstances that involve catatonia, acute suicidality, or nutritional compromise subsequent to refusing food.

C. Psychotherapy as an adjunct to the above options: Professional standards fail to endorse psychotherapy as a stand-alone initial treatment for psychotic manifestations of MDD. ([American Psychiatric Association, 2006](#)) Cognitive behavioral psychotherapy can be considered as an adjunct to the options discussed above. The American Psychiatric Association has published additional considerations in regard to various types of psychotherapy, and those considerations are summarized in the Procedure Summary, [Psychotherapy for MDD](#) (Major Depressive Disorder) - *Patient selection*. ([American Psychiatric Association, 2006](#)) Circumstances which create added support for psychotherapy to be added to such treatment plans include: (1) significant stressors; (2) internal conflict; (3) interpersonal difficulties/social problems; (4) a personality disorder; & (5) a history of only limited/partial response to treatment plans which did not involve psychotherapy.

Concussion severity	Recommended as indicated below. Concussion severity should only be determined after the following criteria have been met: (1) all signs and symptoms of concussion have cleared; (2) the results of neurological examination have returned to normal; and (3) the results of any neuropsychological tests or other cognitive function tests that might have been performed have returned to baseline or above. Loss of consciousness should not be relied on as a measure of concussion severity. Concussion severity should be determined by the duration and number of
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	<p>postconcussion symptoms, not by whether there was brief loss of consciousness or even whether amnesia alone was one of the symptoms. This means that concussion severity should not be determined in most cases on the day of concussion, but rather only after all symptoms have resolved. (<a href="#">Cantu, 2006</a>) New research suggests mild traumatic brain injury (i.e., concussion) may not be the primary driver of posttraumatic stress disorder and related physical health problems. PTSD and depression are important mediators of the relationship between mild traumatic brain injury and physical health problems. (<a href="#">Hoge, 2008</a>)</p>
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**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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)