



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 01/04/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Psychotherapy x 6 Days/Sessions

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

Licensed 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.

Individual Psychotherapy x 6 Days/Sessions - OVERTURNED

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Right Shoulder MRI, M.D., 09/01/09
- Cervical Spine MRI, Dr., 09/01/09
- Untitled Document, Unknown Provider, 09/09/09, 10/28/09
- Initial Medicine Evaluation, M.A., M. Ed., 09/24/09
- Denial Letter, 10/19/09, 11/13/09
- Environmental Intervention, PsyD., 10/19/09
- MMI Report, D.C., 10/20/09
- Designated Doctor Evaluation (DDE), M.D., 10/29/09
- Pre-Authorization for Work Conditioning, D.C., 11/19/09
- Work Conditioning Prescription, Healthcare Rehabilitation, Undated
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient sustained an injury to his right shoulder, head, upper back and right hand. He lost consciousness for approximately three to six minutes. He was transported to the emergency room where he received stitches, x-rays and an injection for pain. He returned back to work soon after the injury and started to feel pain throughout his right shoulder and upper right arm after a week of working. The patient had undergone three weeks of physical therapy. He also underwent MRI's of the right shoulder and cervical spine. He was reported to be taking over the counter Advil.

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

The requested six 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. The documentation 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. The ODG recommends a brief course of psychotherapy and that the MMPI-2 is "Not recommended as an initial screening tool for all cases of chronic pain" (see complete guidelines listed below).

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 post-traumatic 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)

Minnesota Multiphasic personality inventory (MPI): Recommended to determine the existence of suspected psychological problems that are comorbid with chronic pain, to help to tailor treatment. Not recommended as an initial screening tool for all cases of chronic pain. The MMPI and a revised version, MMPI-2, provide a psychological questionnaire that contains three validity scales and ten clinical scales that assesses the patient's levels of somatic concern, depression, anxiety, paranoid and deviant thinking, antisocial attitudes, and social introversion-extraversion. The instrument, one of the most commonly used assessment tools in chronic pain

clinics, can be useful to evaluate which behaviors and expressions related to pain are secondary to psychological stress and which are related to personality traits. The tool has not been shown to be useful as a screening tool for multidisciplinary pain treatment or for surgery. It is not recommended as an initial screening tool for general psychological adjustment in relationship to chronic pain. It cannot be used to corroborate the differential between organic and functional-based pain. Several MMPI profiles have been described in relation to pain patients:

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 anti-depressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80 percent relapse rate with anti-depressants versus 25 percent with psychotherapy). (DeRubes, 1999, (Goldapple, 2004). An additional study found that combined therapy (anti-depressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997). A recent meta-analysis concluded that psychological treatment combined with anti-depressant 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 (anti-depressant) and psychotherapy. **ODG Psychotherapy Guidelines:** Initial trial of six visits over six 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 six 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).

ODG recommended 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 two to four 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 six 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 six 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 six weeks and only CBT is continued during an additional six month period is an important new finding. (Morin, 2009)

All of ODG documentation provide 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)