

## Notice of Independent Review Decision

### **DATE OF REVIEW:**

07/09/2010

### **IRO CASE #:**

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

(90806 IPT) individual psychotherapy one time a week for six weeks.

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

Board Certified Clinical Psychologist

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

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.

**The requested (90806 IPT) individual psychotherapy one time a week for six weeks is not medically necessary.**

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

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

The injured individual is a male with date of injury xx/xx/xx. The injured individual sustained the lumbar injury performing repetitive lifting of forty pound boxes. He complains of back pain radiating down his left leg. Per the injured individual his current medications include Darvocet-N 100mg one tablet three times per day and Lyrica 75mg one tablet two times per day. His attending provider (AP) has requested assessment due to persistent pain and adjustment issues.

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

Based on review of the Initial Behavioral Medicine Consultation, the evaluation completed did not provide credible evidence of psychological impairment. This evaluation was completed by an LPC intern under the supervision of Mr. (a counselor). Based on documentation, a clinical psychologist did not participate or supervise this evaluation. Objective psychological testing was not completed. Assessment of the injured individual's capability to read and appreciate the test items administered was not completed despite evidence of an impoverished educational background. As result of these problems, the Initial Behavioral Medicine Consultation cannot be relied upon to establish a clinical diagnosis. It is also not a credible assessment to base a clinical treatment plan on and it was not reasonable to utilize this evaluation to request individual psychotherapy. Therefore based on the submitted documentation, the requested (90806 IPT) individual psychotherapy one time a week for six weeks is not medically necessary.

Official Disability Guideline provides for recommendations for psychological treatment for appropriately identified patients during treatment for a work-related injury. 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 (ODG, ODG –TWC, ODG Treatment. Integrated Treatment/Disability Duration Guidelines Mental Illness & Stress, pages 1-12).

In this case, a dispute arose over the results of an Initial Behavioral Medicine Consultation completed by a counselor intern under the supervision of Licensed Counselor, on 04/22/2010. This evaluation included self-assessment inventories only and did not incorporate the results of objective psychological testing such as administration of the BHI-2, MMPI-2, or PAI. Three self-report inventories were utilized and presumably administered in Spanish: FABQ, BAI, and BDI-11. These are self-report inventories are known to have poor sensitivity and specificity within a population of injured individuals. Since it is known that up to 30% of injured individuals for workers compensation benefits are exaggerated, but important to administer tests with validity scales a test which measure attempts to exaggerate or minimize problems to manipulate evaluation outcomes.

The results of self-reported anxiety indicated a result suggesting "mild anxiety". Results of self reported depression provided evidence of "minimal" depression. Results of a self-assessment of the kinesophobia suggested significant fear and avoidance of physical activity.

As part of the psychodiagnostic clinical interview, the injured individual was also asked to rate several behavioral dimensions such as pain and interference of pain on his activities. In evaluating these dimensions, the injured individual's self-ratings ranged from 8-10 on a VAS scale.

Mental status was also evaluated and clinical observations were offered by the LPC intern. It was noted that the injured individual was cooperative, presented with normal orientation, normal neurosensory and motor activity, normal memory, and normal intellectual functioning. His mood was anxious and his affect was appropriate to content. All other MSE measurements fell within normal limits.

Following this evaluation, the following DSM-IV diagnosis was offered:

AXIS I: 309.28, Adjustment Disorder with Mixed Anxiety and Depressed Mood, acute, secondary to the work injury.

A request was then submitted requesting six sessions of individual therapy. The reviewing clinical psychologist initially denied the request for individual psychotherapy citing the results of assessment using the BAI and BDI-II. An appeal was submitted by Mr. indicating that the injured individual likely did not understand the Beck instruments and has no formal education. Mr. emphasized that the injured individual's VAS assessments suggested impairment. Despite making these points, individual psychotherapy was again denied following an appeal by another psychologist.

### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

#### **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines

Low Back Chapter:

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](#)) Cognitive behavioral therapy (CBT) significantly improves subacute and chronic low back pain both in the short term and during 1 year compared with advice alone and is highly cost-effective, a new RCT suggests. Disability scores as measured by the Roland Morris questionnaire improved by 2.4 points at the end of 12 months in the CBT group compared with 1.1 points among control patients. Patients were treated with up to 6 sessions of group CBT, whereas controls received no additional treatment other than a 15-minute session of active management advice. According to self-rated benefit from treatment, results showed that 59% of patients assigned to CBT reported recovery at 12 months compared with 31% of controls. Fear avoidance, pain self-efficacy, and the Short Form Health Survey physical scores also improved substantially in the CBT group but not in the control group. The CBT taught people how to challenge their fear of making things worse and to test out ways of improving their physical activity. ([Lamb, 2010](#)) See also Multi-disciplinary pain programs in the [Pain Chapter](#). See also [Psychosocial adjunctive methods](#) in the Mental Illness & Stress 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)

Official Disability Guidelines:

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](#)) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. ([Gatchel, 1999](#)) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. ([Goldberg, 1999](#)) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. ([Linton, 2002](#)) Other studies and reviews support these theories. ([Perez, 2001](#)) ([Pulliam, 2001](#)) ([Severeijns, 2001](#)) ([Sommer, 1998](#)) In a large RCT the benefits of improved depression care (antidepressant

medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. ([Lin-JAMA, 2003](#)) See "[Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients](#)" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI 2<sup>nd</sup> ed - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superseded by the MBMD following, which should be administered instead], (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale – VAS. ([Bruns, 2001](#)) Chronic pain may harm the brain, based on using functional magnetic resonance imaging (fMRI), whereby investigators found individuals with chronic back pain (CBP) had alterations in the functional connectivity of their cortical regions - areas of the brain that are unrelated to pain - compared with healthy controls. Conditions such as depression, anxiety, sleep disturbances, and decision-making difficulties, which affect the quality of life of chronic pain patients as much as the pain itself, may be directly related to altered brain function as a result of chronic pain. ([Baliki, 2008](#)) See also [Comorbid psychiatric disorders](#). See also the [Stress/Mental Chapter](#).

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](#))

**PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

- ¾ *Handbook of Pain Syndromes*. Mahwah, NJ: Lawrence Erlbaum Publishers, 1999-pages 77-97.
- ¾ American College of Occupational and Environmental Medicine. *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers*. Massachusetts: OEM Press, 2<sup>nd</sup> Edition, 2003.
- ¾ Nielson, W.R. & Weir, R. (2001). "Biopsychosocial approaches to the treatment of chronic pain." *Clinical Journal of Pain*, 17(4 Suppl), S114-S127.
- ¾ Roberts, A. H., R. A. Sternbach, et al. (1993). "Behavioral management of chronic pain and excess disability: long-term follow-up of an outpatient program." *Clin J Pain* 9(1): 41-8.
- ¾ Flor, H., D. J. Behle, et al. (1993). "Assessment of pain-related cognitions in chronic pain patients." *Behav Res Ther* 31(1): 63-73.
- ¾ Maloney, K et al. An overview of outcomes research and measurement. *J Health Care Quarterly*, 1999; Nov-Dec; 21(6):4-9.
- ¾ Lambert MJ, editor. Bergin and Garfield's handbook of psychotherapy and behavior change. 5<sup>th</sup> ed. John Wiley and Sons, New York. 2004.
- ¾ Gatchel, Robert J., *Clinical Essentials of Pain Management*, 2005, American Psychological Association.
- ¾ Turk, D.C. & Gatchel, R.J. (Eds.). *Psychological Approaches to Pain Management: A Practitioner's Handbook*, Second Edition. New York: Guilford Press, 2002.