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Notice of Independent Review Decision

DATE OF REVIEW: 05/24/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Individual Psychotherapy (90806) 1x6,
Biofeedback Therapy 1x4 (90901 – EMG, PNG & TEMP)

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

Diplomate, American Board of Pain Medicine
Diplomate, American Board of Psychiatry and Neurology in Psychiatry
Diplomate, American Board of Quality Assurance and Utilization Review
American Society of Addiction Medicine
Health and Human Services certification for outpatient Suboxone detoxification.

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Partially Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 03/26/09 through 05/07/10
2. Addendum, 03/27/09
3. Health, 08/17/09, 02/22/10
4. D.O., 08/24/09, 10/19/09, 02/08/10, 03/15/10
5. Evaluation Center, 10/09/09
6. Bone and Joint, 02/03/10
7. Direct, 03/26/10
8. 04/21/10
9. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

Initial documentation shows no improvement from six sessions of individual psychotherapy per the utilization review company. treatment center were reviewed. Patient is diagnosed with an adjustment disorder with mixed anxiety and depressed mood. March 17, 2010 BDI and BAI are shown to have improved. There was reference to improvement with medications. Elavil is the only psychotropic medication noted however. Dosage is not specified. The patient was injured with a contusion to the knee and shoulder pain and was working regular duty as of April 8, 2009. Extensive shoulder and knee physical therapy was provided. Patient started to see Dr. June 22, 2009. LEFT shoulder and RIGHT knee sprain strain was the impression. There were rule out diagnoses. MRI LEFT shoulder showed a partial or full-thickness tear. Licensed professional counselor evaluation August 24, 2009 diagnosed an adjustment disorder with mixed anxious and depressed mood. Individual psychotherapy is recommended. Physical therapy was done. Currently she's gained significant weight since the injury specifically 30 pounds as of September 2009 for 6 months. Apparently the patient continues no work status. Psychosocial issues are addressed in psychotherapy. She was fired 2 weeks after her injury. Injury was that she tripped and fell hurting her LEFT arm and RIGHT knee. She has comorbid diabetes. She is 5 foot and weighs 270 pounds. February 3, 2010 Dr. thinks she may have a meniscal tear in her RIGHT knee. X-rays are consistent with degenerative changes. Lesion of distal femur is diagnosed. CT scan is recommended. Meniscal tear is diagnosed-Dr. February 8, 2010. CT scan of the knees is consistent degenerative changes. There is a sclerotic lesion in the distal RIGHT femur. It is a nonspecific finding. Correlation with various orthopedic diagnoses including bone cancers is recommended. Breathing exercises are done along with psychotherapy. Biofeedback and psychotherapy is requested March 17, 2010. Orthopedic and oncology evaluation from Dr. is recommended March 15, 2010.

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

Mood symptoms are currently improving with psychotherapy; however, the employee was recently told she may have bone cancer. Although the workers compensation setting may not be the appropriate venue for addressing any feeling she may have in regard to this, additional psychotherapy is reasonable and necessary and there does appear to be some improvement based on subjective report.

Biofeedback therapy 1x4 (90901 – EMG, PNG & TEMP) would not be medically necessary based on the medical records reviewed and the ***Official Disability Guidelines***.

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

American Psychiatric Association treatment guidelines for depression
http://www.psych.org/psych_pract/treatg/pg/Depression2e.book.cfm

Official Disability Guidelines: Cognitive therapy for depression

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](#))

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)

Biofeedback-ODG chronic pain

Biofeedback

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 <low back.htm>](#) 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 <low back.htm>](#)) ([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 <low back.htm>](#)) 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

ODG knee accessed December 15, 2007 Electromyographic biofeedback treatment

Not recommended. Studies are limited. One randomized controlled trial concluded that electromyographic biofeedback treatment for patellofemoral pain syndrome did not result in further clinical improvement when compared with a conventional exercise program in patients with patellofemoral pain syndrome. ([Dursun, 2001](#))