

Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX 75038

972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: APRIL 29, 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
722.10	90806		Prosp	6					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 36 pages of records received to include but not limited to: Notice of IRO 4.8.10; TDI letter 4.8.10; letter 3.22.10; 4.1.10; Mental Health Evaluation; records Dr. 4.30.09- 2.20.10 Bone and Joint records 4.30.09, 1.21.10; Rehabilitation Center records 12.24.09;

Requestor records- a total of 35 pages of records received to include but not limited to: TDI letter 4.8.10; records Dr. 4.30.09- 2.20.10 Bone and Joint records 4.30.09, 1.21.10; MMPI-2 report 12.3.09

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx who was injured at work on xx/xx/xx while performing her usual job duties as an employee for xxxx. On the above-mentioned date, claimant reports she was picking up a bag of laundry when she felt burning and hurting in her lower back. She continued working for a week then was sent to Medical Center. She continued working until some time in 2006. Since then, patient has been in an off-work status. Records indicate she has subsequently been fired from her job.

Since the injury, patient has received conservative, secondary, and tertiary treatments/diagnostics to include: lumbar and cervical x-rays, MRI's, CT scan, FCE, physical therapy, chronic pain program, injections, lumbar surgery x2, and medications management. Current prescribed medications include: Lyrica, Hydrocodone, Flexor patches, Celebrex, Ambien, and Cymbalta.

Patient continues to report high levels of pain in her lower back, and is being suggested for a third lumbar surgery. On 12/10/09, an initial behavioral diagnostic screening was conducted to evaluate and make pre-surgical recommendations regarding patient mental status. Beck Depression Inventory of 17 indicated mild-moderate levels of depression. Beck anxiety inventory was in the moderate range. Sleep questionnaire indicated moderate to serious sleep disturbances related to physical pain, stress, and worries about her current situation. MMPI-2 profile revealed elevated conversion V pattern and also elevated Scale 8. MMPI-2 report revealed patient "is probably experiencing personality deterioration and is likely to have problems with intense anxiety, somatic distress, agitation, and anger. She is likely to demand much attention for somatic complaints. MBMD shows that she "is extremely sensitive to physical changes, which can result in many hypochondriacal complaints." Patient was given a diagnosis of Adjustment disorder with mixed anxiety and depressed mood, chronic, and pain disorder associated with work related injury, medical condition and psychological factors. Axis II diagnosis was deferred. Current request is for 1x6 individual therapy sessions in order to decrease depression and anxiety, improve sleep, improve post-surgical outcome, and teach relaxation and pain coping skills.

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 orthopedic specialist followed ODG guidelines when he recommended a psychological screening for the patient, who clearly deserves this low level of intervention at this time, per ODG, in order to decrease fears and psychosocial stressors which could interfere with post-surgical advancement. As such, current request is considered medically reasonable and necessary to treat the psychosocial symptoms arising from the patient's injury related pain and off-work status, prior to undergoing third lumbar surgery.

Psychological Screening: *Recommended as an option prior to surgery, or in cases with expectations of delayed recovery.* Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as MMPI (Minnesota Multiphasic Personality Inventory) and Waddell signs. ([Scalzitti, 1997](#)) ([Fritz, 2000](#)) ([Gaines, 1999](#)) ([Gatchel, 1995](#)) ([McIntosh, 2000](#)) ([Polatin, 1997](#)) ([Riley, 1995](#)) ([Block, 2001](#)) ([Airaksinen, 2006](#)) A recent study concluded that psychological distress is a more reliable predictor of back pain than most diagnostic tests. ([Carragee, 2004](#))

Psychological Screening; Pain Chapter 2009: Recommended based upon a clinical impression of psychological condition that impacts recovery, participation in rehabilitation, or prior to specified interventions (e.g., lumbar spine fusion, spinal cord stimulator, implantable drug-delivery systems). ([Doleys, 2003](#)) 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 2nd ed - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superceded by the MBMD following, which should be administered instead], (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMII-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](#).

CBT: Recommended. Behavioral treatment 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.

Initial therapy for the “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)

Psychological Screening; Low Back Chapter 2009: Recommended as an option prior to surgery, or in cases with expectations of delayed recovery. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as MMPI (Minnesota Multiphasic Personality Inventory) and Waddell signs. ([Scalzitti, 1997](#)) ([Fritz, 2000](#)) ([Gaines, 1999](#)) ([Gatchel, 1995](#)) ([McIntosh, 2000](#)) ([Polatin, 1997](#)) ([Riley, 1995](#)) ([Block, 2001](#)) ([Airaksinen, 2006](#)) A recent study concluded that psychological distress is a more reliable predictor of back pain than most diagnostic tests. ([Carragee, 2004](#)) The new ACP/APS guideline as compared to the old AHCPR guideline is a bit stronger on emphasizing the need for psychosocial assessment to help predict potentially delayed recovery. ([Shekelle, 2008](#)) For more information, see the [Pain Chapter](#) and the [Stress/Mental Chapter](#)

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](#))

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

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
- 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)