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Notice of Independent Review Decision

DATE OF REVIEW: 04/15/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Outpatient individual counseling, two (2) times a week for three (3) weeks or six (6) sessions as related to right knee

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

Texas Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Follow up notes from Dr. 05/19/08 thru 06/30/08
2. MRI of the left knee dated October, 2008
3. Physical performance evaluation dated 11/19/08
4. Psychological evaluation dated 11/19/08
5. Handwritten chronic pain management weekly goal sheet and progress report dated 01/12/09, 01/27/09
6. Physical performance evaluation dated 01/23/09
7. Psychological evaluation dated 12/23/09
8. BHI-2 Basic interpretive report dated 01/04/10
9. Follow up notes dated 01/08/10, 02/05/10, 03/05/10
10. Notice of utilization review findings dated 01/12/10 and 02/08/10
11. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female whose date of injury is . On this date the employee was driving xxxx when the xxx was hit by a vehicle on the passenger side of the door. The employee sustained injuries to her cervical area and right knee.

The employee underwent a psychological evaluation on 11/19/08 to determine her appropriateness for a chronic pain management program. Treatment prior to this time included diagnostic testing, total knee replacement surgery on 08/04/08, injection therapy, physical therapy and twenty days of work hardening. Medications are listed as Amitriptyline, Meloxicam and Tramadol. BDI is 20 and BAI is 24. The employee was diagnosed with chronic pain disorder.

The employee subsequently underwent a chronic pain management program in December, 2008/January, 2009. Progress note dated 01/27/09 indicates BDI is 14 and BAI is 9.

The employee underwent a psychological evaluation on 12/23/09. The employee was not currently working. Medications are listed as Mobic, Zoloft, Elavil and Flector. The employee reported interruptions in sleeping habits as well as irritability, crying spells, sadness, anger, frustration, and nervous. BDI is 15 and BAI is 24. Mood is moderately depressed and her affect is dysphoric, blunted, and flat. Diagnosis is chronic pain disorder associated with both psychological features and general medical condition. The employee was recommended for a course of individual psychotherapy. BHI 2 basic interpretive report dated 01/04/10 indicated that the employee reported an unusually low level of psychological defensiveness and an unusually diffuse pattern of somatic complaints. The employee reported a relatively high level of depressive thoughts and feelings. The employee did not endorse any of the validity items. The employee endorsed 16 of the 26 Somatic Complaints items and the report stated, "although it is possible that her unusual combination of symptoms is caused by multiple objective medical conditions, somatic preoccupation is a more likely explanation, especially if psychosocial risk factors are present".

A request for individual psychotherapy was previously non-certified on 01/12/10 noting that the employee has been treated from primary to tertiary treatment. The employee has completed a chronic pain management program, and the request to provide less intensive behavioral treatment after a more intensive program has been completed and failed was not supported as medically necessary. A partial letter of appeal was submitted for review which indicated that although the employee failed to progress physically, she "showed excellent response to cognitive behavioral therapy in reducing subjective pain complaints and stabilizing depression and anxiety symptoms".

The denial was upheld on appeal on 02/08/10 noting that since completing the chronic pain management program, the employee's current psychological testing scores indicate non-clinically significant changes in scores except for a significant increase in anxiety symptoms. The reviewer reports that the claimant has continued to function psychologically with respect to her depressive symptoms, sleep and fears regarding physical activity and return to work, at the same level that she had at the completion of the CPMP. There is no current empirical evidence that repeating a lower level of behavioral intervention is effective in reducing anxiety symptoms after completing a multidisciplinary treatment program, and the treatment plan of reintroducing concepts previously taught in a CPMP is not supported by available research literature or the **Official Disability Guidelines**.

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

Based on the clinical information provided, the request for outpatient individual counseling, two times a week for three weeks or six sessions is not recommended as medically necessary, and the two previous denials are upheld. The employee has completed a chronic pain management program as well as a work hardening program and has made some progress in each. However, the employee has been unable to sustain achieved gains. There is no indication that the injured worker has continued to practice the pain management skills presented in both rehabilitation programs, nor is there any evidence that she is motivated to return to work or even a more active lifestyle. Given the current clinical data, the requested outpatient individual counseling is not considered medically necessary.

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

ODG Mental Illness and Stress Chapter

<p>Cognitive therapy for depression</p>	<p>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)</p> <p>ODG Psychotherapy Guidelines:</p>
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	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)
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ODG Pain Chapter

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.

(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.

(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery.

(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.

(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.

(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).

(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. (Keel, 1998) (Kool, 2005) (Buchner, 2006) (Kool, 2007) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial

rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See [Chronic pain programs, opioids; Functional restoration programs](#).