

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** NOVEMBER 21, 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
Unk	90806		Prosp	6					Overturned

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

TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 30 pages of records received to include but not limited to: PHMO notice of an IRO assignment; letters 9.29.10, 10.25.10; Behavioral Health records 9.17.10-10.7.10

Requestor records- a total of 48 pages of records received to include but not limited to: letters 9.9.10, 9.29.10, 10.25.10; Behavioral Health records 2.27.08-11.11.10

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

The claimant is a female who was injured on xx/xx/xx while performing her regular job duties as a xxxxx... On the above-mentioned date, patient was in the process of walking outside when she slipped and fell on the handicap ramp, causing injury to her left knee and lower back. Patient has not returned to work since the accident.

Since the injury, claimant has received the following diagnostics and interventions: MRI's (positive), meniscal repair surgery (5/2008), left knee arthroscopy with synovectomy, chondroplasty, and partial meniscectomy (7/2010), post-surgical PT. Current medications include Hydrocodone, Dolphin.

Current psychometric testing shows severe scores on the FABQ, with patient scoring 23/24 on the Physical subscale and 42/42 on the work subscale. She scored a 45 on the BDI and a 28 on the BAI. Mental status exam revealed suicidal ideation without intent, and patient signed a no-harm agreement and was referred for psychotropic medication management. On a scale of 1-10, patient's pain level is rated, on average, as a 7/10 with patient reporting constant perception of pain. Patient also reports pain significantly interferes with her social and recreational activities, and she has difficulty with bathing, and playing with her grandchildren. Patient is diagnosed with 309.0 Adjustment disorder with mixed anxiety and depressed mood. The current request is for 1x6 IT sessions in order to employ cognitive-behavioral and coping skills intervention for decreasing depressed/anxious mood and relaxation training for improved anxiety and sleep response.

## **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.**

Patient has been referred by her treating physician who understands that her psychological overlay related to her injury, pain, and off-work status is hindering her overall recovery and return to work. Per ODG, a stepped-care approach to treatment has been followed, and as such, this request is considered medically reasonable and necessary.

**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)

**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](#))

**Psychological Screening; Pain Chapter 2010:** 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 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](#).

**Comorbid psychiatric disorders: Recommend screening for psychiatric disorders.** Comorbid psychiatric disorders commonly occur in chronic pain patients. In a study of chronic disabling occupational spinal disorders in a large tertiary referral center, the overall prevalence of psychiatric disorders was 65% (not including pain disorder) compared to 15% in the general population. These included major depressive disorder (56%), substance abuse disorder (14%), anxiety disorders (11%), and axis II personality disorders (70%). ([Dersh, 2006](#)) When examined more specifically in an earlier study, results showed that 83% of major depression cases and 90% of opioid abuse cases developed after the musculoskeletal injury. On the other hand, 74% of substance abuse disorders and most anxiety disorders developed before the injury. This topic was also studied using the National Comorbidity Survey Replication (NCS-R), a national face-to-face household survey. ([Dersh, 2002](#)) See also [Psychological evaluations](#).

Biopsychosocial model of chronic pain; ODG Pain section, December, 2009

See [Chronic pain programs](#) (functional restoration programs), which are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of [delayed recovery](#), including the detailed "Criteria for use of multidisciplinary pain management programs" highlighted in blue. *Definition:* The biopsychosocial model, first proposed by George Engel, MD, acknowledges the important interplay between the biological, psychological, and social systems in illness. While disease is defined as the objective effect of pathology, illness includes the patient's perception of lack of health. An exclusively biomedical focus on objective pathology and disease is of limited usefulness in conditions like chronic pain. A focus on the patient's illness, which includes his or her psychological reactions and social function, may lead to more effective involvement in treatment, with diminished disability, improved function, and diminished co-morbidity. The model focuses on disease and illness, with illness being viewed as an interaction of biological (physiological), psychological and social factors. Disease is defined as the objective event that involves the actual pathology. Pain is experience as a unique experience, and a range of psychological and socioeconomic factors can modulate physical pathology to affect symptoms and subsequent disability. The model is utilized in interdisciplinary pain clinics as patients with chronic pain are at increased risk for emotional disorders, maladaptive cognitions, functional deficits, nociceptive dysregulation, and physical deconditioning. See also [Psychosocial adjunctive methods](#) in the Mental Illness & Stress Chapter

MDD treatment, mild presentations: Recommend options as indicated below. A “mild” manifestation is defined as involving five to six of the diagnostic criteria for a major depressive episode, and a similarly mild presentation of impairment. ([American Psychiatric Association, 2000](#)) Treatment options:

*A. Psychotherapy:* Cognitive behavioral psychotherapy (CBT) has received a clear recommendation for such mild presentations, from the American Psychiatric Association’s Practice Guidelines. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of psychotherapy, and those considerations are summarized in the Procedure Summary, [Psychotherapy for MDD](#) (Major Depressive Disorder) - *Patient selection*. ([American Psychiatric Association, 2006](#))

*B. Medication:* Current practice standards defer to patient preference for much of the treatment planning. ([American Psychiatric Association, 2006](#)) One example is a recommendation that antidepressant medication is an option for such mild presentations, ***IF*** the patient prefers medication over psychotherapy. The American Psychiatric Association has published additional considerations in regard to various types of anti-depressant medications, and those considerations are summarized in the Procedure Summary, [Antidepressants for treatment of MDD](#) (major depressive disorder). ([American Psychiatric Association, 2006](#)) A randomized controlled trial has indicated that the patient’s smoking status is a credible factor that can be considered in the treatment plan. Specifically, anti-depressant medication (fluoxetine/Prozac) has been found to compromise the success of smoking cessation efforts. ([Spring, 2007](#)) Subsequently, if the patient is attempting to quit smoking, that effort causes anti-depressant medication to be a less attractive treatment option than standards typically indicate.

*C. Combined use of both psychotherapy and medication:* Another example of the tendency for professional standards to defer to patient preference is a recommendation for a combined use of psychotherapy and antidepressant medication for mild presentations of MDD, ***IF*** the patient prefers such an approach. ([American Psychiatric Association, 2006](#)) The standards also call for this combined approach ***IF*** the presentation of MDD involves significant social issues/interpersonal problems. ([American Psychiatric Association, 2006](#)) The considerations that were referenced above in regard to psychotherapy and medication options can also be applied to considerations of using both together

MDD treatment, moderate presentations: Recommend options as indicated below. Professional standards call for treatment planning to be based on the severity of the presentation of MDD ([American Psychiatric Association, 2006](#)), but the standards do not provide adequate definitions of what is involved in a moderate or severe presentation. ([American Psychiatric Association, 2000](#)) Subsequently, this discussion will not have the ability to eliminate the confusion that will be caused by attempts to follow professional standards, because confusion is actually inherent to those standards. A “moderate” presentation is defined as falling somewhere between the vague definition of severe presentation (defined as involving most of the diagnostic features for a major depressive episode, and a similarly severe presentation of impairment) and the definition of mild that was discussed above (five to six of the diagnostic features for a major depressive episode, and a similarly mild presentation of impairment). ([American Psychiatric Association, 2000](#))

Treatment options:

*A. Medication:* The American Psychiatric Association strongly recommends anti-depressant medications for moderate presentations of MDD, unless electroconvulsive therapy (ECT) is being planned. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of anti-depressant medications, and those considerations are summarized in the Procedure Summary, [Antidepressants for treatment of MDD](#) (major depressive disorder). ([American Psychiatric Association, 2006](#))

*B. Psychotherapy:* The American Psychiatric Association’s standards note that Cognitive behavioral psychotherapy (CBT) may be considered as a solo initial treatment for moderate presentations of MDD. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of psychotherapy, and those considerations are summarized in the Procedure Summary, [Psychotherapy for MDD](#) (Major Depressive Disorder) - *Patient selection*. ([American Psychiatric Association, 2006](#)) Standards call for psychotherapy to be given special consideration ***IF*** the claimant is experiencing any of the following: (1) significant stressors; (2) internal conflict; (3) interpersonal difficulties; (4) a personality disorder. ([American Psychiatric Association, 2006](#)) A randomized controlled trial has indicated that the patient’s smoking status is a credible factor that can be considered in the treatment plan. Specifically, anti-depressant medication (fluoxetine/Prozac) has been found to compromise the success of smoking cessation efforts. ([Spring, 2007](#)) Subsequently, if the patient is attempting to quit smoking, that effort is an indication that psychotherapy in the absence of anti-depressant medication might be a more acceptable plan than standards would normally indicate.

*C. Combined use of both psychotherapy and medication:* Practice standards endorse using both treatment options for moderate presentations of MDD which simultaneously involve: (1) social issues/interpersonal problems; (2) a personality disorder; & (3) a history of only partial response to treatment plans which involved only psychotherapy or only medication. ([American Psychiatric Association, 2006](#)) The considerations that were referenced above in regard to psychotherapy and medication options can also be applied to considerations of using both together.

MDD treatment, severe presentations: Recommnd options as indicated below. Professional standards call for treatment planning to be based on the severity of the presentation of MDD ([American Psychiatric Association, 2006](#)), but the standards do not provide an adequate definition of what is involved in a severe presentation. ([American Psychiatric Association, 2000](#)) Subsequently, this discussion will not have the ability to eliminate the confusion that will be caused by attempts to follow professional standards. A “severe” manifestation is defined as involving most of the diagnostic features for a major depressive episode, and a similarly severe presentation of impairment. ([American Psychiatric Association, 2000](#)) Treatment options:

*A. Medication:* The American Psychiatric Association strongly recommends anti-depressant medications for severe presentations of MDD, unless electroconvulsive therapy (ECT) is being planned. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of anti-depressant medications, and those considerations are summarized in the Procedure Summary, [Antidepressants for treatment of MDD](#) (major depressive disorder). ([American Psychiatric Association, 2006](#))

*B. Psychotherapy in combination with medication:* The American Psychiatric Association’s standards note that Cognitive behavioral psychotherapy (CBT) may be considered as part of a combined treatment plan for severe presentations of MDD. ([American Psychiatric Association, 2006](#)) The American Psychiatric Association has published additional considerations in regard to various types of psychotherapy, and those considerations are summarized in the Procedure Summary, [Psychotherapy for MDD](#) (Major Depressive Disorder) - *Patient selection*. ([American Psychiatric Association, 2006](#)) Standards call for psychotherapy to be given special consideration ***IF*** the claimant is experiencing any of the following: (1) significant stressors; (2) internal conflict; (3) interpersonal difficulties/social problems; (4) a personality disorder; & (5) a history of limited/partial response to treatment plans which involved only psychotherapy or only medication. ([American Psychiatric Association, 2006](#))

*C. Electroconvulsive therapy:* The American Psychiatric Association’s standards endorse electroconvulsive therapy (ECT) as a treatment option for severe manifestations of MDD, presentations which specifically involve acute suicidality, cases in which nutritional compromise has occurred subsequent to the claimant refusing food, cases which involve catatonia, or cases which involve psychosis (psychotic presentations are discussed individually below). ([American Psychiatric Association, 2006](#))

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

- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- XX OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES ([American Psychiatric Association, 2006](#))