

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 08/08/11

**IRO CASE NO.:**

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

Item in dispute: reconsideration of denial of individual psychotherapy 1 x week for 4 weeks

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

Texas Board Certified Psychiatrist

**REVIEW OUTCOME**

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

Denial Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. M.D., 03/16/10, 12/01/10
2. Lower extremity electrodiagnostic evaluation, 08/26/10
3. 08/27/10 thru 09/30/10, 10/05/10
4. M.D., 08/30/10
5. MRI of the lumbar spine, 09/10/10
6. Medical Center, 10/12/10, 11/01/10, 11/03/10, 11/17/10, 11/30/10, thru 12/10/10, 01/28/11, 02/22/11
7. M.D., 10/22/10
8. Physical medicine & rehabilitation treatment plan, 11/09/10
9. Diagnostics, 12/14/10, 02/25/11
10. Modern Spine, 12/14/10, 02/10/11, 04/12/11, 05/25/11
11. M.D., 12/27/10
12. Operative report, 01/29/11, 05/18/11
13. 04/04/11
14. Rehabilitation, 05/09/11, 06/06/11

15.06/17/11

16.07/22/11

**17. Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a male who sustained an injury on xx/xx/xx while lifting a windmaster.

The employee completed eight sessions of physical therapy from 11/01/10 to 12/02/10.

The employee was seen for a Designated Doctor Evaluation on 12/01/10. The employee complained of pain in the low back and legs rating 7 out of 10. Current medications included Vicodin, Flexeril, and Celebrex. Physical examination revealed no tenderness to palpation of the low back or sacrum. Straight leg raise was to 65 degrees bilaterally in the supine position and 70 degrees bilaterally in the seated position. Sensation was intact to pinprick and light touch. Lumbar range of motion testing revealed flexion to 38 degrees, extension to 6 degrees, right lateral bending to 12 degrees, and left lateral bending to 8 degrees. The employee was assessed with lumbosacral strain/sprain. The employee was not placed at Maximum Medical Improvement (MMI) at that time.

The employee underwent bilateral L5-S1 transforaminal epidural steroid injection on 01/19/11.

The employee was seen for a Designated Doctor Evaluation on 03/16/11. The employee complained of low back pain and leg pain rating 7 to 8 out of 10. Current medications included Vicodin, Flexeril, Naproxen, Gabapentin, Amitriptyline, and Lisinopril. Physical examination revealed no sensory loss. There was no tenderness to palpation of the lumbar spine, sacrum, coccyx, or sciatic notch. Straight leg raise was to 60 degrees bilaterally in the supine position. Lumbar range of motion testing revealed flexion to 40 degrees, extension to 10 degrees, right lateral bending to 24 degrees, and left lateral bending to 20 degrees. The employee was assessed with L5-S1 lumbosacral disc protrusion. The employee was placed at MMI and assigned a 5% whole person impairment.

Electrodiagnostic studies performed 03/30/11 revealed no evidence of motor neuron disease, lumbar radiculopathy, or peripheral neuropathy.

The employee was seen for psychological diagnostic interview on 05/09/11. Current medications included Gabapentin and Vicodin. The employee stopped taking Amitriptyline one month prior due to side effects. The employee's BDI score was 26, indicating moderate depression. The BAI score was 30, indicating severe anxiety. The FABQ-W score was 24 and the FABQ-PA score was 42, indicating a severe level of fear. The employee was assessed with pain disorder associated with both psychological factors and a general medical condition. The employee was recommended for four sessions of individual psychotherapy.

The employee underwent left L5-S1 hemilaminectomy with medial facetectomy and foraminotomy with L5-S1 discectomy on 05/18/11.

The employee saw Dr. on 05/25/11 for postoperative evaluation. Physical examination revealed a well-healing wound without signs of infection. The employee was advised to follow-up in three weeks.

The request for 4 sessions of individual psychotherapy was denied by utilization review on 06/01/11 as guidelines recommend separate psychotherapy after four weeks of lack of progress from physical therapy alone. There are no current or recent physical therapy sessions indicated from the clinical documentation. An addendum dated 06/07/11 stated the employee underwent spinal surgery on 05/18/11. The certification of MMI was withdrawn.

The request for 4 sessions of psychotherapy was denied by utilization review on 06/17/11 due to a lack of controlled studies, randomized clinical trials, or other high quality evidence supporting the use of unimodal psychotherapeutic techniques is producing reliable functional improvements and/or reduction of disability with this type of chronic benign pain syndrome.

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

The request for reconsideration of denial of individual psychotherapy 1 x week for 4 weeks is recommended as medically necessary. The employee's psychological diagnostic testing reveals moderate to severe levels of depression and anxiety. The employee has attempted psychotropic medication, but discontinued secondary to side effects. The employee continues to have pain despite surgical intervention and physical therapy. Individual psychotherapy would be indicated to address any underlying psychological issues that could be delaying the employee's progress. As such, medical necessity is established.

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

*Official Disability Guidelines*, Pain 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 comorbid 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) See also Psychosocial adjunctive methods in the Mental Illness & Stress Chapter. Several recent reviews support the assertion of efficacy of cognitive-behavioural therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). (Kröner-Herwig, 2009)