

CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

Notice of Independent Review Decision

DATE OF REVIEW: November 28, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

6 sessions of individual counseling

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

This is a Board Certified Psychologist with over 24 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

02/08/11: Evaluation at Healthcare Systems by MEd, LPC
07/11/11: Designated Doctor Evaluation by MD
08/22/11: Evaluation at Healthcare Systems by MD
09/15/11: Pre-Certification Request by MEd, LPC
09/22/11: UR performed by PhD

09/23/11: Evaluation at Healthcare Systems by MEd, LPC
??/??/11: Appeal Letter by MEd, LPC
10/11/11: UR performed by PhD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured when he was injured on xx/xx/xx. It was reported that while moving a roll of rubber in a, he twisted and strained his body while holding a 120 pound roll, falling to the floor. His treatment has included conservative care, physical therapy, ESIs, and work hardening, 20 sessions. Current medications are Ultram, Amrix, Cymbalta, ibuprofen, and amitriptyline.

On February 8, 2011, the claimant was evaluated by MEd, LPC at the request of his treating physician, MD. He was referred for a psychological evaluation to determine the appropriateness of a Work Hardening program. During the interview it was reported his average daily pain was 7/10 and the pain was present 100% of the time. The claimant was given a Clinical Interview, Beck Depression Inventory (17) which indicated mild depression, Beck Anxiety Inventory (9) which indicated mild anxiety, Fear Avoidance 21; 38, McGill Pain Questionnaire = 9;3, Pain Level 7, Sleep 4 hours. DSM IV Diagnostic Impressions: Axis I: Chronic pain disorder associated with both psychological features and general medical condition. Depressive Disorder NOS. Axis II: V71.09. Axis III: 847.2, 724.2, 722.10, 724.8, 728.85. Axis IV: Problems with primary support group. Occupational problems. Economic problems. Axis V: GAF 55 (current) Highest Past Year (75) Prior to Injury (75). Dr. recommended 10 sessions of Work Hardening.

On July 11, 2011, the claimant had a Designated Doctor evaluation by, MD who opined that claimant had obtained maximal medical improvement on April 4, 2011 with a 0% whole person impairment.

On August 22, 2011, the claimant was re-evaluated by MD for sharp low back pain coursing into his left leg with numbness and weakness. It was noted that his neurosurgeon, Dr., was recommending a 2-level L4 through S1 lumbar laminectomy with fusion and instrumentation. On physical examination he was in no acute distress. He had left-sided L5 and S1 motor nerve root weakness of 4.5/5. Positive straight leg raising test in the supine position at 30 degrees on the left with equivocal Bragard. Segmental guarding at L4-5 and L5-S1, left greater than right. Decreased left iliopsoas muscle strength of 4/5. He was continued off work and Dr. prescribed Ultram 50 mg, Ibuprofen 800 mg, Amrix 15 mg, Amitriptyline 10 mg, and Cymbalta 30 mg. Dr. also recommended 6 sessions of individual counseling.

On September 15, 2011, , MEd, LPC sent a Pre-Certification Request. Supervising Psychologist listed as PhD. Diagnosis: Axis I: 311, 307.89. Axis II: V71.09. Axis III: 724.5, 338.2. Axis IV: Problems with primary support group, occupational problems, and economic problems. Axis V: GAF Score (Current: 45, highest past year: 45. Prior to injury: 69). Request for individual counseling sessions, 1.5 hours per session, 2 times per week for 3 weeks. It was reported that Dr. referred him for evaluation for

depression after he scored a 51 on his BDI questionnaire. I was noted that he had not had any individual counseling and presented with perceived disability, anxiety, depression, inadequate strategies to manage pain during the day, and symptoms of insomnia due to pain. He continued to have negative thoughts, decreased socialization, and was leading an inactive lifestyle at home. Planned Intervention Modalities: 1. Supportive psychotherapy/empathic listening. 2. Coping skills training. 3. Pain management training. 4. Provided psycho-education re; causes and management of chronic pain. 5. Provide cognitive behavioral therapy. 6. Facilitate grief process. Long Term Goals: 1. Stabilization of depressive mood. 2. Stabilization of irritable/angry/dysphoric mood. 3. Independent utilization of pain management skills. 4. Independent utilization of stress management skills. 5. Independent utilization of effective psycho-physiological self-regulation skills. 6. Development of improved coping skills. 7. Improve sleeping patterns. 8. Increase daily activity level and live as full a life as possible with physical limitations.

On September 22, 2011, PhD performed a UR on the claimant. Rationale for Denial: The mental health evaluation of 2/8/11 finds impressions of pain disorder and depressive disorder. However, this is now 7 months old and not instructive for any proposed treatment at this time. The submission of a current "test score" on a BDI and a GAF rating is irrelevant in this regard. This does not constitute an appropriate clinical evaluation of a chronic pain patient. Further, there is no clinical evaluation to integrate any psychometric information. Appropriate interpretation of psychological tests involves synthesizing all relevant data (e.g. medical, historical) with test results, consideration of various 'characteristics of the person' and adequate clinical/behavioral correlation. Finally, there are no controlled studies, randomized clinical trials, or other high quality evidence supporting the use of unimodal psychotherapeutic techniques in producing reliable functional improvements and/or reduction of disability with this type of chronic benign pain syndrome. Per all the above, the patient is not an 'appropriately identified patient' for whom psychotherapy is both reasonable and necessary at this time.

On September 23, 2011, the claimant was re-evaluated by MEd, LPC. It was reported that he perceives himself to have been a good employee prior to the injury and was satisfied with his job at the time. His current physical/mental complaints included very uncomfortable, painful with extended sitting and radiation into his left leg. He was not currently working but expressed a desire to return to work stating that he was frustrated, disgusted, depressed and that he had worked since the age of 13. The claimant was given a Clinical Interview, Beck Depression Inventory (51) which indicated severe depression, Beck Anxiety Inventory (42) which indicated severe anxiety, Fear Avoidance 22; 40, McGill Pain Questionnaire = 2;8, Mankoski Pain Level 8, Sleep 3 hours. DSM IV Diagnostic Impressions: Axis I: Chronic pain disorder. Depressive Disorder NOS. Anxiety Disorder NOS. Axis II: V71.09. Axis III: 847.2, 724.2, 722.10, 724.8, 728.85. Axis IV: Problems with primary support group. Occupational problems. Economic problems. Axis V: GAF 47 (current) Highest Past Year (47) Prior to Injury (75).

On ??, 2011, (The date is listed as August 11, 2011 however, it is clear from the letter that this is the incorrect date.) Dr. wrote a letter of appeal regarding the denial of individual counseling. In the letter she states that the claimant present with severe symptoms of depression and anxiety, despite the use of Cymbalta 30 mg q.d. Inventory scores are high (BDI of 51 and BAI of 42) which are up significantly from the testing performed in February. He appeared depressed during the clinical interview with reported symptoms of weight loss (15 pounds), anger, sadness, frustration, feelings of worthlessness and hopelessness, and avoidance to activities people and places. He also reports sleep loss due to pain, significant pain levels (8/10) with inadequate strategies to manage his symptoms, and significant fear of engaging in physical activity. Dr. goes on to state that the individual psychotherapy is in fact recommended in conjunction with antidepressant medications. That guidelines cite that combined treatment works more effectively than stand alone treatment. She cites several different studies.

On October 11, 2011, PhD performed a UR on the claimant. Rationale for Denial: This injury is over 1 year old, the patient's presentation is consistent with a Chronic Pain Disorder and the evaluation diagnoses a Chronic Pain. ACOEM guidelines state: 'There is no quality evidence to support the independent/unimodel provision of CBT for treatment of patients with chronic pain syndrome. There is no known effective psychotherapeutic treatment for such disorders (somatoform, mood, or anxiety disorders), per se, when the etiology of symptoms involves a chronic benign pain syndrome'. [ACOEM Guidelines (2008). Chapt. 6: Chronic pain; p.277]. Cognitive therapy for depression or anxiety is only appropriate when it is the primary focus of treatment, which is not the case with this patient who is reporting chronic pain. This request also is not consistent with ODG and ACOEM Guidelines concerning the use of individual psychotherapy with this type of patient who is reporting chronic pain. ODG (for chronic pain and back injuries) states 'consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone'. At the present time, there are no current or recent PT sessions. There is no assessment of the patient's inability to benefit from 20 sessions of a work hardening program which also provided the patient with psychological interventions. This presents a poor prognosis for the requested treatment. There are no objectively stated treatment goals for the requested treatment to determine 'objective functional improvements' as required by ODG. These issues indicate that the request is not consistent with the requirement that psychological treatments only be provided for 'an appropriately identified patient'. Based on the documentation provided, ODG criteria were not met.

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

The reviewer finds that the previous adverse determination/adverse determinations should be upheld. The clinical basis for this conclusion includes:

- 1) This injury is over 1 year old, the claimant's presentation is consistent with a Chronic Pain Disorder and the evaluation diagnoses a Chronic Pain. ACOEM guidelines state: 'There is no quality evidence to support the

independent/unimodel provision of CBT for treatment of patients with chronic pain syndrome. There is no known effective psychotherapeutic treatment for such disorders (somatoform, mood, or anxiety disorders), per se, when the etiology of symptoms involves a chronic benign pain syndrome'. [ACOEM Guidelines (2008). Chapt. 6: Chronic pain; p.277]. This request also is not consistent with ODG and ACOEM Guidelines concerning the use of individual psychotherapy with this type of patient who is reporting chronic pain. ODG (for chronic pain and back injuries) states 'consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone'. This presents a poor prognosis for the requested treatment. There are no objectively stated treatment goals for the requested treatment to determine 'objective functional improvements' as required by ODG. (UR review by Ph.D. on October 11, 2011)

- 2) On July 11, 2011, the claimant had a Designated Doctor evaluation by MD who opined that claimant had obtained maximal medical improvement on April 4, 2011 with a 0% whole person impairment.
- 3) The mental health evaluation of 2/8/11 finds impressions of pain disorder and depressive disorder. However, this is now 7 months old and not instructive for any proposed treatment at this time. The submission of a current "test score" on a BDI and a GAF rating is irrelevant in this regard. This does not constitute an appropriate clinical evaluation of a chronic pain patient. Further, there is no clinical evaluation to integrate any psychometric information. Appropriate interpretation of psychological tests involves synthesizing all relevant data (e.g. medical, historical) with test results, consideration of various 'characteristics of the person' and adequate clinical/behavioral correlation. (UR review by Ph.D. on September 22, 2011).

ODG:

<p>Psychological treatment</p>	<p>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:</p> <p><u>Step 1:</u> 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.</p> <p><u>Step 2:</u> 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.</p> <p><u>Step 3:</u> 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)</p>
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	<p>(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)</p>
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ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:

Screen for patients with risk factors for [delayed recovery](#), including fear avoidance beliefs. See [Fear-avoidance beliefs questionnaire](#) (FABQ).

Initial therapy for these “at risk” patients should be [physical therapy](#) for [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)

With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG [Mental/Stress Chapter](#), repeated below.

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)

Extremely severe cases of combined depression and PTSD may require more sessions if documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials. Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders. ([Leichsenring, 2008](#))

<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> <ul style="list-style-type: none"> 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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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**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- 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)**