



Notice of independent Review Decision

DATE OF REVIEW: December 27, 2010

IRO Case #:

Description of the services in dispute:

Individual Psychotherapy (#90806) x 6

Biofeedback (#90901) x 6

A description of the qualifications for each physician or other health care provider who reviewed the decision:

The clinician who provided this review is a licensed Psychologist in two states. This reviewer is a diplomate in Clinical Neuropsychology, by the American Board of Professional Neuropsychology. This reviewer is a member of the American Psychological Association, the American Pain Society and the National Academy of Neuropsychology. The reviewer has served as the Chief of Neuropsychology and Rehabilitation Psychology at a university medical center, an assistant professor of Psychology, Director of a Children's Rehabilitation Program and staff Psychologist. The reviewer is currently in private practice where he has nearly 30 years of experience.

Review Outcome:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be upheld. Six sessions of individual psychotherapy (#90806) and six sessions of biofeedback (#90901) are not medically necessary.

Information provided to the IRO for review:

Received 12/13/10:

- Notice to Utilization Review Agent of Assignment of Independent Review Organization 12/10/10 - 1 page.
- Notice of Assignment of Independent Review Organization 12/10/10 - 1 page.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization 12/10/10 - 5 pages.
- Request for a Review by an Independent Review Organization 12/10/10 - 3 pages.
- Utilization Review Report 11/29/10 - 6 pages.
- Request for Reconsideration from Injury 1 11/18/10 - 2 pages.
- Patient Face Sheet - 1 page.
- History and Physical/Neurological Consultation of MD 11/03/10 - 2 pages.
- Utilization Review Report 11/03/10 - 4 pages.
- Preauthorization Request from Injury 1 of Waco 10/29/10 - 2 pages.
- Prescription from DO for Psychotherapy and Biofeedback 10/28/10 - 1 page.
- Treatment Reassessment from Injury 1 10/28/10 - 3 pages.
- Initial Behavioral Medicine Consultation from Injury 1 08/06/10 - 6 pages.

Received 12/14/10:

- Letter Preauthorization Director, Injury 1 of Waco 12/14/10 – 1 page.
- Notice of Assignment of Independent Review Organization 12/10/10 – 1 page.
- New Patient Office Visits Notes, MD 10/27/10 – 3 pages.
- Report of Medical Evaluation 07/20/10 – 1 page.
- Office Notes of DO 10/20/10 – 1 page.
- EMG/NCV Report 10/21/10 – 5 pages.
- Office Notes of DO 09/22/10 – 2 pages.
- Office Notes of DO 08/31/10 – 2 pages.
- Designated Doctor Evaluation, MD 08/05/10 – 8 pages.
- EMG/NCV Report 08/04/10 – 4 pages.
- Office Notes of DO 07/28/10 – 2 pages.
- Impairment Rating MMI/IR Report, DC 07/20/10 – 4 pages.
- Report of Medical Evaluation, MD 07/07/10 – 10 pages.
- Office Notes of DO 06/21/10 – 2 pages.
- Office Notes of DO 05/22/10 – 2 pages.
- CT Reports of the Brain, Cervical Spine and Facial Bones 02/06/10 – 2 pages.
- MRI Report of the Lumbar Spine 02/19/10 – 2 pages.
- CT Report of the Maxillofacial Region 02/16/10 – 2 pages.

Patient clinical history [summary]:

The claimant is a female who suffered injuries to her head, neck, and shoulder in a motor vehicle accident on xx/xx/xx. Medical documentation submitted for review indicated that the claimant was a passenger in an 18 wheeler in when the truck hit some ice on the road and started sliding, swerved, and then rolled.

A psychological evaluation completed on 08/06/10 indicated that the claimant was suffering from severe depressive symptoms and anxiety. Diagnostic impressions included major depressive disorder (MDD) and refractory pain. Multiple neurological symptoms including loss of consciousness, dizziness, imbalance, confusion, loss of sensation, headaches, visual problems, and memory deficits were also reported. It was noted that neuropsychological testing had not yet been completed when the request for individual psychotherapy and biofeedback was submitted. The request for psychological intervention was denied.

Submitted documentation indicated that six sessions of individual psychotherapy were completed prior to this request for six additional psychotherapy sessions. It appears that no biofeedback treatment was provided prior to this request. Submitted documentation provided evidence of improvement in functioning following the provision of the six sessions of individual psychotherapy.

A psychological evaluation completed on 08/06/10 provided evidence of profound impairment including significant problems with activities of daily living. For example, the claimant reported she

was unable to comb her hair and had a difficult time dressing including putting on her undergarments. Significant insomnia was noted in addition to impaired mood. Significant self-reported depression was noted on a depression screening inventory. Significant evidence of severe anxiety was noted on a screening inventory for anxiety.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision:

Prior denials of six sessions of individual psychotherapy (#90806) and six sessions of biofeedback (#90901) are upheld. Insufficient objective psychological testing was submitted to provide a differential diagnosis for the claimant and establish the clinical necessity of the proposed treatment. While evidence of a significant concussion was provided, including loss of consciousness, there is no evidence that a differential neuropsychological evaluation has been completed to establish a reasonable basis for providing a psychological diagnosis and developing a psychological treatment plan. ODG is organized by diagnosis. In order to establish an appropriate and credible diagnosis, a recommendation for neuropsychological testing was submitted to the treating professionals. This appears to have been a reasonable recommendation and should be implemented prior to developing and implementing a psychological treatment plan. The request for psychological treatment including biofeedback and individual psychotherapy based on the present diagnosis of major depressive disorder and refractory pain is premature and not clinically necessary at this time. Neuropsychological testing should be completed to obtain a differential diagnosis related to a possible concussion and postconcussion syndrome related to a rollover accident/MVA prior to requesting additional psychological treatment.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ODG
Biofeedback Not recommended as a stand-alone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. There is fairly good evidence that biofeedback helps in back muscle strengthening, but evidence is insufficient to demonstrate the effectiveness of biofeedback for treatment of chronic pain. Biofeedback may be approved if it facilitates entry into a CBT treatment program, where there is strong evidence of success. As with yoga, since outcomes from biofeedback are very dependent on the highly motivated self-disciplined patient, we recommend approval only when requested by such a patient, but not adoption for use by any patient. EMG biofeedback may be used as part of a behavioral treatment program, with the assumption that the ability to reduce muscle tension will be improved through feedback of data regarding degree of muscle tension to the subject. The potential benefits of biofeedback include pain reduction because the patient may gain a feeling that he is in control and pain is a manageable symptom. Biofeedback techniques are likely to use surface EMG feedback so the patient learns to control the degree of muscle contraction. The available evidence does not clearly show whether biofeedback's effects exceed nonspecific placebo effects. It is also unclear whether biofeedback adds to the effectiveness of relaxation training alone. The application of biofeedback to patients with CRPS is not well researched. However, based on CRPS

symptomology, temperature or skin conductance feedback modalities may be of particular interest. (Keefe, 1981) (Nouwen, 1983) (Bush, 1985) (Croce, 1986) (Stuckey, 1986) (Asfour, 1990) (Altmaier, 1992) (Flor, 1993) (Newton–John, 1995) (Spence, 1995) (Vlaeyen, 1995) (NIH–JAMA, 1996) (van Tulder, 1997) (Buckelew, 1998) (Hasenbring, 1999) (Dursun, 2001) (van Santen, 2002) (Astin, 2002) (State, 2002) (BlueCross BlueShield, 2004) This recent report on 11 chronic whiplash patients found that, after 4 weeks of biofeedback training, there was a trend for decreased disability in 36% of the patients. The authors recommended a randomized–controlled trial to further explore the effects of biofeedback training. (Voerman, 2006) See also Cognitive behavioral therapy (Psychological treatment) and Cognitive intervention (Behavioral treatment) in the Low Back Chapter. Functional MRI has been proposed as a method to control brain activation of pain. See Functional imaging of brain responses to pain.

ODG biofeedback therapy guidelines:

Screen for patients with risk factors for delayed recovery, as well as motivation to comply with a treatment regimen that requires self–discipline. Initial therapy for these at risk patients should be physical therapy exercise instruction, using a cognitive motivational approach to PT.

Possibly consider biofeedback referral in conjunction with CBT after 4 weeks:

- 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)
- Patients may continue biofeedback exercises at home

Psychotherapy

Behavioral interventions

Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See also Multi–disciplinary pain programs.

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 medicine for exercise instruction, using a cognitive motivational approach to physical medicine.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone:

- 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)