CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: **7-13-11**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 6 sessions CPT 90806

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

Psychologist

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)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

ER visit - the claimant was provided with a diagnosis of cervical sprain, back sprain and elbow contusion. He was given a prescription for Vicodin and Valium.

CT of the head/brain was negative.

CT scan of the cervical spine shows no acute bony abnormality. Multilevel degenerative disc disease and spondylosis.

X-rays of the left elbow was negative.

X-rays of the thoracic spine shows mild multilevel thoracic spondylosis.

5-23-11 MD., the claimant reports that while driving a Humvee at work on, he lost control and the vehicle rolled over landing on its top. He was not ejected from the vehicle. He was wearing his seatbelt. He had immediate pain in his left elbow. Then over the next several days he began to experience head, neck and back pain. He has no known loss of consciousness. After about a half an hour, a rescue crew located him as he was walking around and was transported to emergency department via ambulance. X-rays and MRIs were reportedly within normal limits. He was treated with Vicodin and a muscle relaxer. He was sent home for one day and returned to full work status. He has not had any physical therapy. He was referred to Injury for further workup and evaluation. On exam, his neck is supple without nodes. His thoracic spine has myospasms between the shoulder blades. He has full range of motion on flexion, extension and rotation. He has a negative straight leg raise bilaterally. He has good strength in his lower extremities. His upper extremities have full range of motion on supination and pronation, good grip and strength. He is tender over the cubital groove of the left elbow. His neurovascular exam is intact. Impression: Status post closed head injury with possible loss of consciousness secondary to motor vehicle accident. Post-concussion headaches, cervical sprain/strain secondary to MVA. Thoracic sprain/strain secondary to MVA, right shoulder sprain/strain secondary to MVA, right shoulder contusion secondary to MVA, left elbow sprain/strain secondary to MVA, left elbow contusion secondary to MVA. Plan: PT evaluation and treatment. Psych intake evaluation. Set him up an appointment to see Dr. as soon as possible. Send for his outpatient records from Hospital. Flexeril 10 mg, #30, 1 po tid prn muscle spasms, no refills. He was returned to full work status without restrictions.

5-26-11, MD., the claimant was involved in a motor vehicle accident on xx//xx. He was going at a fairly slow rate of speed when he rolled his Humvee over in a ditch. He was not ejected from the vehicle. No loss of consciousness. He was wearing his seatbelt during the injury. He was ambulating at the scene when the ambulance arrived. Patient

was transported to Hospital via ambulance. X-rays and CT scan of his head were reported as normal by the patient. Records are still pending on this dictation. He was discharged to home with Vicodin and muscle relaxers. He is referred to Injury Clinic for workup and evaluation. Today Mr. still describes some mild pain and tenderness in the right side of his scalp with some radiation into the right side of his neck. He denies any neuropathy in his arms or legs. He does describe some mild pain radiating into his right clavicle. He denies any headache, nausea or vomiting associated with this injury. He has got some mild pain over his left elbow, but he is able to move his left arm normally. Full range of motion of the left elbow. He has got some mild scalp tenderness over the right posterior occipital region of the scalp. On exam, his neck shows good range of motion to flexion, extension and rotation. He has got some very mild paracervical muscle spasming and tenderness on the right. His left elbow shows good range of motion to flexion, extension, supination and pronation, but some mild tenderness to the olecranon of the elbow, but no swelling or inflammation noted. Impression: Scalp contusion, closed head injury, cervical sprain/strain, thoracic sprain/strain, left elbow sprain/strain, and contusion to the left elbow. Plan: Physical therapy evaluation and treat, Norco 7.5/325, 1 bid prn while not at work, 60 tablets; Motrin 600 mg, tid prn. Will change him to light-duty work restrictions.

5-26-11 Physical therapy initial evaluation.

5-27-11 Initial Behavioral Medicine Consultation performed by, MS, LPC/, MS, CRC, LPC., the claimant appeared to be appropriate for his stated age. He was cooperative throughout the interview. He was oriented times five to date, person, place, situation, and time. His attention, motor activity, and speech were all deemed to be normal. His memory for both recent and remote events was intact. Intellectual functioning was within normal limits. His mood was euthymic. His affect was appropriate to content His thought process was goal-directed. His thought content revealed problem minimizing. He did not hallucinate or appear delusional. Judgment, insight and impulse control were noted as good. No current risk factors were indicated.
When asked to quantify his symptoms numerically, the patient reveals the following: irritability and restlessness, 7/10; frustration and anger, 8/10; muscular tension/spasm, 8/10; nervousness and worry, 5/10; sadness and depression, 2/10; sleep disturbance, 9/10; and forgetfulness/poor concentration, 8/10. Results of the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) reveal the following: The patient scored 9 on the BDI-II, indicative of minimal depression. He scored I on the BAI, indicative of minimal anxiety. Mr. responses on the Fear Avoidance Beliefs Questionnaire (FABQ) revealed significant fear avoidance of physical activity in general (FABQ-PA = 17), though did not reveal fear avoidance of work (FABQ-W = 22). Multiaxial diagnosis: Axis I: R/0 293.83 Mood Disorder secondary to head trauma. Axis: V71.09, no diagnosis. Axis III: Injury to neck, shoulder and elbow - See medical records. Axis IV: Primary support group and Occupational Problems. Axis V: GAF = 62 (current). Estimated pre-injury GAF = 85+. Based on the information gathered through the initial interview with our offices and the patient's presentation and verbal report, we would determine that the work accident, pain, and ensuing functional limitations have caused this patient's disruption in lifestyle, leading to moderate disturbances in sleep, mood. He appears to have been functioning independently prior to the work injury of xx/xx/xx. Since the work injury the patient has experienced some of the following: personal physical illness or injury, change in financial status, and difficult work conditions. The initial evaluation that we completed in our office suggests that the claimant would greatly benefit from a brief course of individual psychotherapeutic intervention using

CBT auto genic and progressive muscle relaxation with guided imagery/hypnotherapy to facilitate a healthy adjustment and improve his pain related sleep disorder with his overall condition by using basic relaxation techniques. This should assist him in developing tools and skills for the management of his injury-related disturbances. The patient should receive immediate authorization for participation in a low level of individual psychotherapy for a minimum of 6 weeks. He expect that this level of treatment will create a very positive response in his physical rehabilitation program and accelerate his recovery while simultaneously resolving sleep issues and developing a plan to expedite his return to normal sleep functioning. Possible neuropsychological evaluation if head injury symptoms fail to abate with treatment.

6-7-11, DC., performed an impairment rating evaluation. He certified the claimant had not reached MMI. He reported that the claimant is enrolled and participating in a physical therapy program for the treatment of sprain/strain to the neck, upper back, right shoulder and left elbow.

6-17-11 PhD., performed a Utilization Review. There is no evidence that these minimal psychological symptoms constitute a delay in the 'usual time of recovery' from this acute Injury (Work Loss Data Institute, ODG 2011). The patient is experiencing acute pain from the injury. Guidelines state that 'in patients with chronic pain psychological reactions become the major contributors to impaired functioning'. However, with acute pain, 'pain is still related to tissue damage' and 'is not yet compounded by the motivational, affective, cognitive, and behavioral overlay that is often a frustrating aspect of chronic pain' (ACOEM Guidelines, Chapter 6). This is a new injury with acute pain. The patient is actively involved in the continued evaluation and treatment of this new injury. Additional treatment of this injury was recently approved (PT sessions) and there is no report of lack of progress from this current medical treatment. At this time, there is no reason to believe that the current active rehabilitation will be insufficient to restore functional status. The evaluation does not identify specific behavioral or psychological findings that suggest risk factors for delayed recovery or chronicity. There is no evidence that these reported minimal psychological symptoms constitute a delay in the 'usual time of recovery' from this acute injury, thus requiring the requested treatment. The patient was released to return to work with no restrictions and has returned to work. There is no evidence that this patient is at risk for delayed recovery, Furthermore, head trauma is identified in the evaluation, but not assessed. The request is not consistent with the requirement that psychological treatments only be provided for 'an appropriately identified patient'. Based on the documentation provided, ACOEM and ODG criteria were not met. It is recommended that the request for individual psychotherapy x 6 is not reasonable or necessary.

6-21-11 PsyD/ PhD., provided a response to the UR. The evaluator reported It seems like Dr. did not review all the medical records. Initially, he was released full duty on 5-23-11 but due to his limitations, he was placed on light duty restrictions as of 5-26-11. He has completed 7/12 PT although patient still complains of pain at 6/10. His CT head/brain w/o contrast was negative. He does complain of having frequent and severe headaches. A brief course of individual psychotherapy would help him to learn relaxation techniques to reduce intensity of headaches/pain. He also would benefit from learning sleep hygiene techniques to increase his sleep from 5 to 6 hours. He is having some mood disturbance due to his injury which would benefit from CBT to help him view his problems from overwhelming to manageable.

6-28-11, PhD., performed a Utilization Review. The evaluator discussed this case and requested procedure with Dr.. The clinical indication and necessity of this procedure could not be established. The mental health evaluation finds impressions of r/o mood disorder secondary to bead trauma. Without evidence of TBI, this is difficult to appreciate. There are no cognitive or behavioral sequelae which could be attributed to TBI. Furthermore, the utilized psychometric instruments (limited to BM, BDI, FABQ) are inadequate/inappropriate to elucidate the pain problem, explicate psychological dysfunction, or inform differential diagnosis in this case; and there is no substantive behavior analysis to provide relevant diagnostic information [ACOEM. (2008). Chronic pain. Occupational Medicine Practice Guidelines, 2nd ed.; p. 314-320], In particular, the FABQ is valid for patients presenting
with low back pain, with respect to fear-avoidance beliefs about work and fear-avoidance beliefs about physical activity [Waddell G4 et al. (1993). A Fear-Avoidance Beliefs Questionnaire (FABQ) and the role of fear avoidance beliefs in chronic low back pain and disability. Pain, 52, 157-168]. The validity of the FABQ for the current pain presentation (both empirically and on its face) is highly questionable, resulting in a likely inflated estimate of the patient's dysfunction and disability. The offering that the patient's 'thought content revealed a problem minimizing' Is clinically meaningless. There is no appropriate standard to reference in this regard. Appropriate treatment cannot be based on inadequate evaluation, i.e., 'Mental health science is primarily categorized by diagnosis, therefore a credible diagnostic formulation is of the greatest importance for evaluation and treatment planning.' [Official Disability' Guidelines. (2011). Mental illness & stress]. There is no documentation, and no other data now provided, of specific, antecedent or current psychosocial risk factors predictive of a 'delayed recovery' or risk of chronicity in this case, thus requiring psychological or behavioral services to prevent, resolve or reduce Official Disability Guidelines. (2011). Pain: ACOEM. (2008). Chapt. 5: Cornerstones of disability prevention and management. Occupational Medicine Practice Guidelines, 2nd ed.; p. 00-61]. There is no empirical support for 'elevated pain in PT' as a risk factor for chronicity. Further, such is impossible to assess. 'Pain is a psychological or experiential phenomenon that is inaccessible to objective measurement. The assumption that [pain scales] are linear 'measures' of internal pain states has been tested and has not been validated for patients with chronic pain, postoperative orthopedic patients, and other clinical groups.' [ACOEM. (2008). Chronic pain. Occupational Medicine Practice Guidelines, 2nd ed.; p. 102]. There is no indication that the current physical therapy will be inadequate to restore premorbid or reasonable functional status, i.e., at this time there is no evidence of 'lack of progress from PT,' as a required indication for psychotherapy in this type of case.

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

THE PATIENT HAS AN INJURY DATE OF XX/XX/XX. HE REPORTEDLY SUSTAINED INJURIES IN AN MVA AT WORK. HE HAS HAD DIAGNOSTICS, PHYSICAL THERAPY, AND MEDICATIONS. HE WAS NOTED TO NOT BE AT MMI ON 6/07/11 AS HE WAS STILL RECEIVING PHYSICAL THERAPY. A BEHAVIORAL MEDICINE EVALUATION DATED 5/27/11 NOTES THAT HE IS TAKING NORCO, MOTRIN, AND FLEXERIL. HE RATES HIS PAIN AS 7/10 AND WAS WORKING WITH RESTRICTIONS. HE REPORTED DECREASED SLEEP AND SOME SELF-REPORTED PROBLEMS BUT HIS SCORE ON THE BDI WAS 9 AND ON THE BAI WAS 1. HE WAS NOTED TO HAVE SOME FEAR-AVOIDANCE ISSUES FOR ACTIVITY. HE WAS GIVEN A DIAGNOSIS OF MOOD DISORDER, NOS. THE

RECENT MEDICAL NOTES INDICATE A REFERRAL FOR A PSYCHOLOGICAL EVALUATION BUT DO NOT OUTLINE PSYCHOLOGICAL SYMPTOMS OF DISTRESS OR A RATIONALE FOR THE REFERRAL. THE PATIENT HAS HAD VERY LITTLE TREATMENT FOR THIS INJURY AND IS ABLE TO WORK. HE SELF-REPORTS LOW DEPRESSION AND HIS BECK SCORES ARE WITHIN THE NORMAL RANGE. GIVEN THE RECENT INJURY AND LIMITED TREATMENT NOTED TO DATE AS WELL AS A LACK OF INFORMATION ON PROGRESS IN PHYSICAL THERAPY OR AN UPDATED TREATMENT PLAN AS WELL AS HIS LOW SELF-REPORT AND SCORES FOR DEPRESSION AND ANXIETY, THE REQUEST FOR INDIVIDUAL PSYCHOTHERAPY X 6 SESSIONS (CPT 90806) CANNOT BE ESTABLISHED AS REASONABLE AND NECESSARY, PER EVIDENCE-BASED GUIDELINES.

ODG-TWC, last update 5-31-11 Occupational Disorders - Pain – 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. (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)

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)**