

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** JUNE 15, 2011 AMENDED: JUNE 17, 2011

**IRO CASE #:**

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

Medical necessity of proposed 3 sessions of Individual Psychotherapy (90806) and 3 sessions of medication monitoring (90862)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Psychiatry and is engaged in the full time practice of medicine.

### **REVIEW OUTCOME**

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

- Upheld (Agree)  
 Overturned (Disagree)  
XX 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
847.2	90806		Prop	3					Overturned
847.2	90862		Prop	3					Upheld

Request for an IRO-18 pages

URA records- a total of 22 pages of records received to include but not limited to:

Notice of an IRO assignment; letter 5.26.11; letters 3.15.11, 4.12.11; Centers records 2.22.11-4.4.11

Requestor records- a total of 20 pages of records received to include but not limited to:

Cover letter; Notice of an IRO; fax confirmation; request for an IRO forms; Centers records 2.22.11-4.7.11

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

The patient had a slip and fall injury on xx/xx/xx. She developed low back pain and possible radicular symptoms that have persisted despite conservative treatment. Psychological evaluation was completed including some psychological testing with a conclusion that she has a pain disorder. Recommendation was for a trial of psychotherapy and medication management.

### **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/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

Recommendation is partial authorization. Recommend authorization of the 3 psychotherapy sessions and non authorization of the medication management sessions.

Rationale: The ODG does not specifically address medication management, but the request for this does not seem individualized to this patient. The patient has a treating provider who is prescribing pain medications. There is not note of abuse of these agents, and she is on low dosages. It is not clear from the evaluation why coordination of treatment with the treating doctor cannot be accomplished by the therapist to help achieve therapeutic goals. She is not sleeping well. The primary treatment for this should be cognitive behavioral therapy. The ODG does support a trial of psychotherapy for chronic low back pain with delayed recover as cited below:

Recommended as option for patients with chronic low back pain and delayed recovery. Also recommended as a component of a Chronic pain program (see the [Pain Chapter](#)). Behavioral treatment, specifically cognitive behavioral therapy (CBT), may be an effective treatment for patients with chronic low back pain, but it is still unknown what type of patients benefit most from what type of behavioral treatment. Some studies provide evidence that intensive multidisciplinary bio-psycho-social rehabilitation with a functional restoration approach improves pain and function. ([Newton-John, 1995](#)) ([Hasenbring, 1999](#)) ([van Tulder-Cochrane, 2001](#)) ([Ostelo-Cochrane, 2005](#)) ([Airaksinen, 2006](#)) ([Linton, 2006](#)) ([Kaapa, 2006](#)) ([Jellema, 2006](#)) Recent clinical trials concluded that patients with chronic low back pain who followed cognitive intervention and exercise programs improved significantly in muscle strength compared with patients who underwent lumbar fusion or placebo. ([Keller, 2004](#)) ([Storheim, 2003](#)) ([Schonstein, 2003](#)) Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate on this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). ([Lang, 2003](#)) A recent RCT concluded that lumbar fusion failed to show any benefit over cognitive intervention and exercises, for patients with chronic low back pain after previous surgery for disc herniation. ([Brox, 2006](#)) Another trial concluded that active physical treatment, cognitive-behavioral treatment, and the two combined each resulted in equally significant improvement, much better compared to no treatment. (The cognitive treatment focused on encouraging increased physical activity.) ([Smeets, 2006](#)) For chronic LBP, cognitive intervention may be equivalent to lumbar fusion without the potentially high surgical complication rates. ([Ivar Brox-Spine, 2003](#)) ([Fairbank-BMJ, 2005](#)) Cognitive behavioral therapy (CBT) significantly improves subacute and chronic low back pain both in the short term and during 1 year compared with advice alone and is highly cost-effective, a new RCT suggests. Disability scores as measured by the Roland Morris questionnaire improved by 2.4 points at the end of 12 months in the CBT group compared with 1.1 points among control patients. Patients were treated with up to 6 sessions of group CBT, whereas controls received no additional treatment other than a 15-minute session of active management advice. According to self-rated benefit from treatment, results showed that 59% of patients assigned to CBT reported recovery at 12 months compared with 31% of controls. Fear avoidance, pain self-efficacy, and the Short Form Health Survey physical scores also improved substantially in the CBT group but not in the control group. The CBT taught people how to challenge their fear of making things worse and to test out ways of improving their physical activity. ([Lamb, 2010](#)) See also Multi-disciplinary pain programs in the [Pain Chapter](#). See also [Psychosocial adjunctive methods](#) in the Mental Illness & Stress Chapter.

**ODG cognitive behavioral therapy (CBT) guidelines for low back problems:**

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 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)

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

- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES