CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

DATE OF REVIEW: **3-22-11**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1 x 6 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]:

6-25-09 LPC., performed an initial Behavioral assessment. Diagnosis: Axis I: 307.89 Pain Disorder associated with both psychological factors and a general medical condition, secondary to the work injury. 296.21 Major Depressive Disorder, single episode, mild, secondary to the work injury. Axis II: V71.09, no diagnosis. Axis III: Injury to left wrist-See medical records. Axis IV: Primary support group issues. Axis V: GAF — 65 (current) Estimated pre-injury GAF = 85+. Summary & treatment recommendations: to summarize, the claimant has experienced a compensable work injury that required much medical treatment with temporary and/or limited benefit. At this time, the claimant appears to have developed a chronic pain syndrome. He has not responded to all other care as expected. Pain continues to negatively impact his functioning across broad domains. That is, he exhibits pain behavior, functional limitations, and dysfunction that are disruptive to his activities of daily living. The patient is facing significant, permanent loss of functioning that requires major physical, vocational, and behavioral readjustment. His pain has persisted beyond the expected tissue healing time. He has physical impairment that requires treatment in a more structured/supervised setting. He is not a surgical candidate at this time. Results of the clinical assessment suggest that the patient is likely to benefit from immediate involvement in an interdisciplinary chronic pain rehabilitation program as prescribed by his treating doctor, Dr.. Ability to participate in and benefit from treatment: All information gathered through the clinical assessment suggests that this patient would very well be suited for a course of intensive pain control intervention and rehabilitation for a minimum of 10 days. Outpatient unimodal counseling therapy did little to improve the patient's functional ability and productivity. Although his affect and coping improved with outpatient individual psychotherapy, his physical functioning and productivity did not. Subjective pain remains in the severe range. It is likely that he would be best served in an interdisciplinary team environment in concert with the physical rehabilitation to ensure independent application of pain control strategies. He is suited for cognitive-behavioral approaches and psychophysiological training techniques to include guided imagery, tense-relax protocols, and the like. This patient should be considered for alternative methods for pain control to foster an internal locus of control. Behavioral therapy coupled with physical rehabilitation and medicine, should improve his prognosis much better than traditional psychotherapy of physical rehabilitation alone.

1-25-10, PA/, DO., the claimant is seen for follow up. The claimant continues with some pain and discomfort. The claimant has seen orthopedic surgeons and the have recommended no further surgical intervention. The evaluator

recommended light duty.

10-13-10 EMG/NCS of the left upper extremity performed by MD., showed left carpal tunnel syndrome, left C8 acute/chronic radiculopathy.

12-1-10 DO., the claimant reports he has severe left wrist pain and is depressed and is requesting to see a counselor. The claimant is to see Dr. for therapeutic injection on
12-15-10 and then follow up with his orthopedic surgeon. The claimant is continued off work. The evaluator recommended a psychological intake and evaluation as soon as possible. The claimant is to proceed with injections.

12-3-10, MD., the claimant had EMG/NCS showing left median neuropathy consistent with carpal tunnel syndrome as well as evidence of left C8 radiculopathy. He is following up with Dr. regarding possible carpal tunnel release. He has been wearing a wrist splint. It has been mildly helpful. He is tolerating medications well and has been stable without significant side effects. He continues to have increased numbness and pain on the ulnar aspect of his left arm going to his 4th and 5th digits. The pain is going up into his neck as well. It is noted that his left wrist apparently is this only area covered under Worker's Compensation currently. On exam, there is some tenderness in the left lower cervical spine with some mild pain with cervical flexion and lateral rotation. Some difficulty lifting his left arm over his head as well as below his back. The claimant has a positive Tinel's on the left. There is also some decreased sensation on the ulnar aspect of the left forearm as well as the 4th and 5th digits of the left hand. Normal motor strength in the bilateral deltoids, biceps, triceps, and grip strength within normal limits, except decreased grip strength on the left. Plan: It appears that patient has 2 issues going on left carpel tunnel syndrome as well as left lower cervical radiculopathy. The claimant will be following up with Dr. regarding surgical options regarding carpal tunnel syndrome. After this was successfully treated, he would potentially recommend treatment for the radiculopathy including a trial of epidural steroids and/or a neurosurgical referral. Continue current medications without changes. He is stable and having increased functioning and no significant side effects. Check a urine drug screen for patient safety and compliance.

1-5-11 DO., the claimant is still having pain in his neck and left wrist. He received an injection to the left wrist. His has two pending. The evaluator recommended a psychological evaluation through MHMR, follow up with Dr.. The claimant is to see an orthopedic surgeon.

1-18-11 MS, LPC/, MS, CRC, LPC, Health and Behavioral assessment. The re-evaluation that she completed in our office suggests that the claimant would greatly benefit from a brief course of individual psychotherapeutic intervention using CBT techniques to facilitate a healthy adjustment and improve his coping with his overall condition by using basic relaxation techniques. His subjective endorsements suggest he is struggling with his pain experience and loss of function. 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 brief course of individual psychotherapy for a minimum of 6 weeks. Further, they will work to reduce disturbances in mood and resolve psychosocial stressors by providing the appropriate community resource referrals. They expected that this level of treatment will create a very positive response in his physical rehabilitation program and accelerate his recovery while simultaneously resolving psychosocial stressors and developing a plan to expedite his return to normal functioning.

1-28-11 PhD., performed a Utilization Review. The evaluator discussed with Dr.. The patient is currently attending bi-weekly counseling at and monthly medication management sessions at, however, these records have not been reviewed by Dr. and the patient's treating diagnosis at is unknown. The current evaluation also does not attempt to assess the factors that may have contributed to the patient's inability to benefit from previous psychological interventions including a multidisciplinary chronic pain management program, Without an adequate assessment of these factors, the appropriateness of the requested treatment could not be determined ((Work Loss Data Institute, ODG, Guidelines, 2011; Guidelines for the assessment and management of chronic pain, Institute for Clinical Systems Improvement (ICSI), 2005; ACOEM Guidelines, Chapter 6). ODG state that additional psychological treatments should only be provided with evidence of objective functional improvement' from previous psychological treatments (Work Loss Data Institute, ODG, Guidelines, 2011). No objective functional improvements are reported as the result of previous psychological interventions including a multidisciplinary chronic pain management program. The patient continues to use opioid medications and has not return to work. The patient's inability to benefit from previous psychological interventions including a chronic pain management program indicates a poor prognosis for the requested treatments (Work Loss Data Institute, ODG, Guidelines, 2011), Thus, the request is inconsistent with the criterion: "At the conclusion (of a chronic pain management program) and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g., work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program)". Furthermore, this is a x year old injury and the patient's presentation was consistent with a Chronic Pain Syndrome and a Pain Disorder is diagnosed. ACOEM guidelines state: "There is no quality evidence to support the independent/unimodal 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. 227]". 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 low back) states "consider separate psychotherapy CRT referral after 4 weeks if lack of progress from PT alone". 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. It is recommended that the request for individual psychotherapy x 6 is not reasonable or necessary. He contacted Dr. who stated she was authorized to discuss this case. Treatment goal, the patient's treatment history, the patient's progress and the patient's current psychological symptoms were discussed. He recommended an adverse determination.

2-23-11 PhD., the evaluator 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 of 1/18111 finds impressions of pain disorder and major depressive disorder. However, the utilized psychometric instruments are inadequate/inappropriate to elucidate the pain problem, explicate psychological dysfunction, or support differential diagnosis in this case; and there is no substantive behavior analysis to provide relevant diagnostic information. In addition, the patient's history and clinical presentation is clearly consistent with inference of a chronic benign pain syndrome, as this commonly understood, which the provider affirms [Official Disability Guidelines. (2011). Pain; ACOEM, (2005). Chronic pain. Occupational Medicine Practice Guidelines, 2°" ed.; p. 112; Chronic Pain Syndrome, 338.4: WHO. (2007). ICD-9 CM). With respect to "somatoform, mood, or anxiety disorders [such as the above diagnoses]. There is no Known effective psychotherapeutic treatment for such disorders, per se, when the etiology of symptoms
involves a chronic benign pain syndrome." [ACOEM. (2008). Chronic pain. Occupational Medicine Practice Guidelines, 2" ed.; P. 321], The patient has been treated with an interdisciplinary pain rehabilitation program, which is generally considered the terminus for treatment of a chronic benign pain problem, including any related psychosocial dysfunction. This type of intervention is based on intensive psychological care (along with physical methods of functional restoration). That there was inadequate response to this program is clearly a negative prognostic sign for any functional or objective improvement from unimodal psychotherapy (and the extended counseling provided already supports that inference). At this time it is not clear what factors may have contributed to a failure of this treatment; and the provider did not obtain relevant history or explore this with the patient. Providing further psychological care in this context is as likely to reinforce pain behavior as to enable any positive therapeutic effect. A criterion of treatment in an interdisciplinary pain rehabilitation program is the completion of all other appropriate care, i.e." There is an absence of other options likely to result in significant clinical improvement." [Official Disability Guidelines. (2011). Pain]. Such a program is generally the termination of any functional or psychological care; and thus, further psychotherapy, without specific acute indications, is not appropriate. There is no effort here to resolve issues of duplication of care, noting that the patient is receiving counseling for this problem elsewhere; and that treatment is already excessive.
Psychotherapy is not always an innocuous procedure, and some patients do experience iatrogenic problems with such treatment [Barlow, D. H. (2010). Negative effects from psychological treatments. American Psychologist, 65(1), 13-20]; symptoms may be intensified in this context; pain behavior may be reinforced; dependency on the therapy may develop; and it should be eschewed where clear indications do not exist or there is lack of objective progress from

previous treatments. Per all the above, the patient is not an "appropriately identified patient" for whom additional psychotherapy is both reasonable and necessary at this time [Official Disability Guidelines. (2011). Pain]. Non- approval is recommended.

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. THE PATIENT REPORTEDLY HAS HAD PHYSICAL THERAPY, DIAGNOSTICS, INJECTIONS, IT, SURGERY, POSSIBLE CPMP IN 2007, AND MEDICATION MANAGEMENT. THE HISTORY NOTES THAT THE PATIENT HAS BEEN PARTICIPATING IN BIWEEKLY COUNSELING AND MEDICATION MANAGEMENT THROUGH, IS ON SSDI, AND THAT A SURGERY MAY BE PENDING. A NOTE FROM DR. DATED 1/05/11 NOTES THAT HE RECOMMENDS A PSYCHOLOGICAL EVALUATION AT. IT APPEARS THE CLAIMANT IS SEEN AT. THERE IS NO INFORMATION ABOUT PROGRESS IN THIS SETTING.

CONTACTED 3/21/11 AT 4PM AND SPOKE WITH WHO STATED DR. NO LONGER WORKED AT THAT FACILITY. SHE REVIEWED THEIR RECORDS AND STATED THAT THEY HAD NO INFORMATION THAT THE CLAIMANT WAS BEING SEEN AT.

BASED ON THE RECORDS PROVIDED, THE REQUEST FOR ADDITIONAL I.T. IS NOT REASONABLE OR MEDICALLY NECESSARY, PARTICULARLY SINCE THE CLAIMANT IS BEING PROVIDED WITH IT AT AND THERE IS NO INFORMATION REGARDING TREATMENT PROVIDED AT THIS FACILITY.

ODG-TWC, last update 3-21-11 Chronic 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-behavioral 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)**