



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 1-31-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1 x 6 (6 visits); Biofeedback therapy 1 x 6 (6 visits) 90806, 90901

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]:

xxxxx PA/ MD., the claimant reported that while at work xxxxx striking him on the back. He had immediate pain, but did not see a doctor for xxxx days. He is transferring his care in to injury since he lives in xx. He has had no x-rays, MRI's or physical therapy to date. He was seen by Dr. in the clinic. He was given Vicodin 7.5/500 bid for pain, and some Mobic. On exam, He ambulates slowly. His back has significantly decreased active and passive range of motion on flexion, extension and rotation secondary to a significant amount of myospasms on the right side greater than the left. His straight-leg raise is negative bilaterally and deep tendon reflexes are equal bilaterally. Impressions: 1) Thoracic and lumbar contusions. 2) Thoracic and lumbar sprain/strain. Plan: 1) PT evaluation and treatment. 2) Obtain his outpatient records, including those from Injury 1 in 3) Set him up an appointment to see Dr. as soon as possible. 4) Request a psych intake evaluation for depression and anxiety related to the injury. He was given Norco 7.5/500, #45 tablets, 1, po tid prn severe pain, with no refills; Soma 350 mg, #45 tablets, 1 po tid pm muscle spasms, with no refills. 6) He was placed on light duty, with multiple work restrictions. 7) He will be seen back in the office in one month. 8) He will call if symptoms increase.

9-15-11 MD., the claimant presents for evaluation of his low back pain. He was initially seen, but has not had any significant workup for that yet. The claimant has continued to work light-duty work restrictions and he comes today from work, but states he has intermittent severe pain in his lower back, with intermittent pain radiating into his buttocks. His back exam did show a moderate amount of point tenderness over the paralumbar musculature, increased with flexion and extension of the back, as well as rotation. He has got negative straight-leg raising signs bilaterally. Deep tendon reflexes are symmetric in his lower extremities and upper extremities. Plan: Physical therapy, MRI scan of the lumbar spine, light duty work restrictions, refill Norco, discontinue Soma and change it to Flexeril.

9-26-11, PA/, MD., the claimant saw Dr. a week ago. That dictation is not available at this time. He continues to have quite a bit of pain and discomfort. He continues to work light-duty. He has difficulty getting in and out of his vehicle, he discussed the fact that he needs to turn, his body to get in and out of the vehicle rather than to be twisting and bending at the waist, etc. He has been scheduled for an MRI and that has not been approved as of yet. On exam, he has difficulty getting in and out of the chair. He has a positive straight-leg raise on the right. He has decreased active and passive range of motion on flexion, extension and rotation of his lumbar spine. He has significant myospasms on the right side greater than the left.

Impressions: Thoracic and lumbar contusions, thoracic and lumbar sprain/strain. Plan: He received no written prescriptions today. He will continue with his light-duty work restrictions for another 30 days. They are still waiting for an MRI to be approved. He will be seen back in the office in one month. He will call if symptoms worsen.

12-13-11 Individual Psychotherapy treatment reassessment summary: diagnosis: AXIS I: Pain disorder associated with both psychological factors and a general medical condition, acute. Major depressive disorder, single episode, severe without psychotic features. AXIS II: No diagnosis. AXIS III: Injury to back. AXIS IV: Primary support group, economic and occupational. AXIS V: Current GAF = 59, estimated prior to injury 05+. The claimant's response to treatment was positive. While the claimant showed progress in session and at home with reducing negative symptoms through utilization of relaxation techniques and abdominal breathing, there is still some report of difficulty performing successfully on her own. Thus the claimant may benefit from additional visual and auditory feedback help to improve self regulation.

12-21-11 Preauthorization request from PsyD or PsyD., for individual psychotherapy 1 x 6 weeks and biofeedback therapy 1 x 6 weeks.

12-27-11 PhD., UR non certification for individual psychotherapy 1 x 6 and Biofeedback therapy 1 x 6. The evaluator discussed this case with Dr.. The clinical indication and necessity of this procedure could not be established. The mental health report of notes impressions of pain disorder and major depressive disorder. Six psychotherapy sessions have been recently provided to date; and there is no indication/documentation of clinically meaningful salutary, objective functional or behavioral change. In fact, the overall clinical picture is that the patient is worse than when he began this care. It is not reasonable to provide additional such treatment. The requested biofeedback is not reasonable and necessary. There are no extent evidence based guidelines, randomized clinical trials, or other high quality evidence supporting the use of unimodal biofeedback techniques, with or without concomitant psychotherapy, in producing objective functional improvements with this type of chronic benign musculoskeletal pain condition. "Biofeedback is 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," [Official Disability Guidelines. (2011), Pain; California DWC. (2009). MTUS: Chronic pain medical treatment guidelines; p, 24]. However, there is no documentation of active physical therapy or evidence that the patient is following a

proscribed exercise regimen at this time; and further CBT has not been recommended/authorized. He was not able to establish a basis that continuing these treatments is both reasonable and necessary at this time. Non-approval is recommended.

1-6-12 PsyD/ PhD., Reconsideration for individual therapy 1 x 6 and biofeedback therapy 1 x 6. Patient has improved ability to cope with pain and limited mobility. Inc has also learned problem solving skills and identified cognitive distortions. However, because the stressors have increased over the past weeks, he is having difficulty adjusting back to normal psychological functioning. It would be prudent that the patient continue psychological treatment. He reports a change in his ADLs. Regarding driving, he reports being able to ride in a vehicle for up to 60 minutes. He also is able to perform light activities around his house such as light cooking/cleaning. He continues to do daily physical therapy exercises at home. His emotions also being able to walk for up to 40 minutes. He also goes grocery shopping with difficulty being trouble reaching for objects. Deficits/Reason for continuation of individual psychotherapy: He is still socially isolated and stays at home. He is having difficulty getting along with his roommate and significant others. Patient reports that many of his negative psychological stressors have increased. He shows that he is much more frustrated and depressed. Increased symptoms may be a result of the patient being fired from his job 11/24/11. This increased his worry about his employability and having to look for a job. He is frustrated that the recovery process is going much slower than he anticipated. He is worried that he is not getting the treatment necessary for physical recovery. In addition to attending monthly appointments with the treating doctor, patient completed 12 sessions of physical therapy. He also attended an orthopedic consult. Patient is scheduled for an epidural steroid injection but has not had this to date. While he has shown progress in session and at home with reducing negative symptoms through utilization of relaxation techniques and abdominal breathing, there is still some report of difficulty performing successfully when alone. He will benefit from individual and biofeedback to utilize visual and auditory feedback to improve his self-regulation.

1-11-12 PhD., UR non certification for individual psychotherapy 1 x 6 and Biofeedback therapy 1 x 6. The patient has now completed 6 recent sessions of individual psychotherapy. The patient continues to report significant pain and there has been no change in psychological symptoms (according to Beck scores, depressive symptoms remain severe and anxiety symptoms remain moderate). Also, the patient is awaiting additional medical treatment (injections). The request is inconsistent with ODG which states that additional psychological treatments should only be provided "with evidence of objective functional improvement" from previous psychological treatments. Guidelines also note that "All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement," The psychological re-evaluation on 12/11/11 indicates that no meaningful functional improvement has been obtained and there has been no change in psychological symptoms (according to Beck Scores). According to Dr., the patient is awaiting further medical treatment (injection). Furthermore, a Chronic 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. 5; 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 CBT referral after 4 weeks if lack of progress from PT alone". At the present time, the patient is awaiting further medical treatment of this injury. Since additional individual psychotherapy is not appropriate for this patient, the necessity of biofeedback training could not be established. Guidelines state that biofeedback is "Not recommended as a stand-alone treatment". ODG (for biofeedback) also recommend "Initial therapy for these "at risk" patients should be physical therapy" and "possibly consider biofeedback referral in conjunction with CBT". At the present time, the patient is awaiting further medical treatment and additional individual psychotherapy sessions are not recommended. Furthermore, the available evidence does not clearly show whether biofeedback's effects exceed non specific placebo effects. It is also unclear whether biofeedback adds to the effectiveness of relaxation training alone." (Work Loss Date Institute, ODG Guidelines, 2011). 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 additional individual psychotherapy x 6 and biofeedback training x 6 is not reasonable or necessary. He contacted Dr. who stated he was authorized to discuss this case at 3:45pm CST on 01-09-2012. Treatment goal, the patient's treatment history, the chronicity of the injury and the patient's current psychological symptoms were discussed. He recommended an adverse determination. He upheld the adverse determination," There may be unresolved issues on this claim regarding compensability or liability or an unresolved dispute to extent of causal relatedness to the injury.

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 HAS HAD VERY LITTLE TREATMENT TO DATE TO INCLUDE PHYSICAL THERAPY, MEDICATIONS, SIX PSYCHOTHERAPY SESSIONS, AND A CONSULT. HE WAS NOTED TO BE TAKING HYDROCODONE AND FLEXERIL. FOLLOWING SIX PSYCHOTHERAPY SESSIONS, LITTLE IMPROVEMENT WAS NOTED. THERE WAS NO CHANGE IN HIS PAIN LEVEL, SELF-REPORTED SCORES OF IRRITABILITY, DEPRESSION, OR MUSCLE TENSION AND HIS FRUSTRATION INCREASED AS DID HIS SLEEP ISSUES. HIS BECK ANXIETY SCORE INCREASED FROM 26 TO 28 AND HIS BECK DEPRESSION SCORE INCREASED FROM 20 TO 35. HE IS NOTED TO HAVE CONTUSIONS AND A STRAIN/SPRAIN. THERE IS INSUFFICIENT EVIDENCE OF OBJECTIVE DOCUMENTATION OF IMPROVEMENT NOTED AND BIOFEEDBACK IS

NOT SUPPORTED BY THE GUIDELINES. THEREFORE, THE REQUEST FOR BIOFEEDBACK (6 VISITS) AND ADDITIONAL PSYCHOTHERAPY (6 VISITS) IS NOT REASONABLE AND MEDICALLY NECESSARY, PER EVIDENCE-BASED GUIDELINES.

ODG-TWC, last update 1-20-12 Occupational Disorders - Pain Chapter:

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 myofeedback 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 myofeedback 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

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)