

# CASEREVIEW

**8017 Sitka Street  
Fort Worth, TX 76137  
Phone: 817-226-6328  
Fax: 817-612-6558**

## Notice of Independent Review Decision

**DATE OF REVIEW:** January 29, 2012

**IRO CASE #:**

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

6 additional visits of individual psychotherapy (90806) and biofeedback therapy 1xwk x 6 wks (EMG, PNG, TEMP)

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

This is a Board Certified Psychologist with over 24 years of experience.

**REVIEW OUTCOME:**

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

Upheld (Agree)

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:**

12/05/11: Individual Psychotherapy Treatment Re-Assessment Summary by Intern and with

12/14/11: UR performed by

01/09/12: UR performed by

**PATIENT CLINICAL HISTORY [SUMMARY]:**

On December 5, 2011, the claimant had a re-assessment of individual psychotherapy treatment. It was reported that the claimant had completed 6 of 6 days of IPT sessions with good benefits. He was post-operative and in post-op PT 6 weeks. Multiaxial Diagnosis: Axis I: Pain Disorder associated with both psychological factors and a general medical condition; acute. Major Depressive Disorder, single episode,

moderate. Anxiety Disorder, NOS. Axis II: no diagnosis. Axis III: Injury to lower back, left knee, left foot. Axis IV: Primary support group, social environment, economic problems, occupational problems, healthcare services, and other psychosocial and environmental problems. Axis V: GAF-current: 64; Estimated pre-injury: 85. It was also reported that despite the claimant's unrelenting pain and limited treatment received, he had made modest gains over a brief time period. The claimant reported that psychotherapy gave him a safe place in which to process his injury and its impact upon his life. The claimant begun practicing abdominal breathing and relaxation techniques; however, had not yet become fully independent in daily effective implementation of the techniques. The claimant also reported making an effort to increase his physical activity level. Overall, the claimant was reported to experience some improvement physically and emotionally since the beginning of IPT. It was reported there had been a significant decrease in the claimant's objective and subjective ratings with pain, irritability, frustration, nervousness, depression, and sleep, however the claimant continued to struggle with muscle tension, forgetfulness, anxiety and depression. Continuation with an additional 6 session of IPT and in addition, 6 sessions of Biofeedback Therapy was recommended in order to help the claimant fully realize treatment objectives.

On December 14, 2011, PhD performed a UR on the claimant. Rationale for Denial: The claimant has now completed 6 recent sessions of individual psychotherapy. The patient continues to report significant pain and is awaiting post surgical PT sessions. 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 12/05/11 indicates that no meaningful functional improvement has been obtained. According to the patient is awaiting post surgical PT sessions. 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. 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 CBT referral after 4 weeks if lack of progress from PT alone.' At the present time, the patient is awaiting post surgical PT sessions and there is no report of 'lack of progress' from the recent surgical intervention. 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 CPT'. At the present time, the patient is awaiting post surgical PT sessions and there is no report of 'lack of progress' from the recent surgical intervention and additional individual psychotherapy sessions are not recommended.

On January 2, 2012, and with submitted a request for reconsideration/appeal for the individual psychotherapy and biofeedback therapy. It was reported that the claimant had significant decreases in his objective and subjective ratings with pain, irritability, frustration, nervousness, depression and sleep. That the claimant continued to struggle with all symptoms in the moderate to severe range, which are directly related to the work injury. It was reported that in most recent note on 12/28/11, the claimant continued to experience injury related anxiety/depression and that he was having trouble coping with his post-operative recovery. It was also stated that due to the claimant's pain and muscle tension not responding to techniques taught in individual therapy alone, they were requesting a trail of biofeedback to address his pain disorder diagnosis.

On January 9, 2012, performed an UR on the claimant. Rational for Denial: I discussed this case and requested procedure with. The clinical indication and necessity of this procedure could not be established. The mental health report of 12/05/11 finds impressions of pain disorder, major depression, and anxiety 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. Therapeutic progress is reported with subjective and psychometric assessments. A change in test scores or other subjective 'measures' is insufficient to demonstrate clinically meaningful progress or effectiveness of this therapy. The putative measurement of progress using putative 'pain levels' here is not clinically meaningful. 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. Thus, continuation of the psychotherapy is not indicated. The requested biofeedback is not reasonable and necessary. "Biofeedback is not recommended as a standalone treatment, but recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity.'

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The adverse determinations are upheld. The request does not meet ODG guidelines. Specifically, additional psychological treatments should be provided 'with evidence of objective functional improvement'. The claimant recently completed 6 sessions of psychological treatment and therapeutic progress was reported with subjective and psychometric assessment. I agree with that the "putative measurement of progress using putative 'pain levels' here is not clinically meaningful". ODG also states that separate psychotherapy should be considered 'after 4 weeks if lack of progress from PT alone'. There is no documentation that would indicate there is or will be a lack of progress from PT alone.

As 6 additional visits of individual psychotherapy is not found to be medically necessary or meet ODG criteria, then biofeedback is also not found to be medically necessary. ODG states that 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'.

ODG:

Behavioral interventions	<p>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. Several recent reviews support the assertion of efficacy of cognitive-behavioural therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). (<a href="#">Kröner-Herwig, 2009</a>) See the <a href="#">Low Back Chapter</a>, “Behavioral treatment”, and the <a href="#">Stress/Mental Chapter</a>. See also <a href="#">Multi-disciplinary pain programs</a>.</p> <p><b>ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:</b>  Screen for patients with risk factors for <a href="#">delayed recovery</a>, including fear avoidance beliefs. See <a href="#">Fear-avoidance beliefs questionnaire</a> (FABQ).  Initial therapy for these “at risk” patients should be <a href="#">physical therapy</a> for <a href="#">exercise</a> instruction, using a cognitive motivational approach to PT.  Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:</p> <ul style="list-style-type: none"> <li>- Initial trial of 3-4 psychotherapy visits over 2 weeks</li> <li>- With evidence of objective <a href="#">functional improvement</a>, total of up to 6-10 visits over 5-6 weeks (individual sessions)</li> </ul> <p>With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG <a href="#">Mental/Stress Chapter</a>, repeated below.</p> <p><b>ODG Psychotherapy Guidelines:</b></p> <ul style="list-style-type: none"> <li>- Initial trial of 6 visits over 6 weeks</li> <li>- With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)</li> </ul> <p>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. (<a href="#">Leichsenring, 2008</a>)</p>
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Biofeedback	<p>Not recommended as a stand-alone treatment, but recommended as an option in a <a href="#">cognitive behavioral therapy</a> (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 low back pain. Biofeedback may be approved if it facilitates entry into a CBT treatment program, where there is strong evidence of success. As with <a href="#">yoga</a>, 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. There is conflicting evidence on the effectiveness of biofeedback for treating patients with chronic low back problems. See the <a href="#">Pain Chapter</a> for more information and references, as well as ODG biofeedback therapy guidelines. (<a href="#">van Tulder, 1997</a>) (<a href="#">Bigos, 1999</a>)</p>
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**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)**