

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: March 6, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual Psychotherapy Sessions x6 90806 Left Ankle, Left Knee, Rt. Shoulder, Back

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:

12/26/11: Initial Behavioral Medicine Consultation at

12/30/11: UR performed by

01/13/12: Request for Reconsideration/Appeal by

01/22/12: UR performed by

02/14/12: UR performed by

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained injuries to his left ankle, left knee, right shoulder, and lower back on xx/xx/xx when he slipped on a plastic pallet causing him to fall. Initially he received 15 sessions of physical therapy and then underwent back surgery on 2/2011 and left knee surgery on 4/2011. He received no post-op physical therapy. He has also had injection therapy, 2 injections in his right shoulder and 1 injection in his left ankle.

On December 26, 2011, the claimant was evaluated by at the request of treating doctor to assess his emotional status and to determine his suitability for some level of behavioral medicine treatment. Current medications were listed as: Hydrocodone 10-325 mg, Lyrica 150 mgt, and Soma 350 mg. It was reported that the claimant's pain was rated a 9 on a 1 to 10 scale. His pain was described as a constant, sharp and aching sensation in his back and right shoulder. It was reported that he had difficulties with the following activities of daily living since his injury: self-grooming/self-care, performing household chores and yard work, cooking, exercising, not able to drive due to pain, sitting for more than 15 minutes, standing for more than 15 minutes, walking for more than ½ mile, bending, squatting, climbing stairs, lifting/carrying objects more than 10 pounds, and engaging in sexual activity. The claimant rated his level of overall functioning in life prior to the injury at 100% and rated his current level of functioning as 30%. The claimant reported both initial and sleep maintenance insomnia. The claimant scored a 39 on the BDI-II, indicating severe depression. His score on the BAI was 12, reflecting mild anxiety. His responses on the Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work (FABQ-W = 42) as well as significant fear avoidance of physical activity in general (FABQ-PA = 24). Multiaxial Diagnosis: Axis I: Pain Disorder associated with both psychological factors and a general medical condition, chronic. Major Depressive Disorder, single episode, severe, without psychotic features. Axis II: No diagnosis. Axis III: Injury to lumbar strain, right shoulder strain, left knee contusion/strain, left ankle sprain and L5-S1 lumbar disc protrusions. Axis IV: Primary support group, problems related to the social environment, economic problems, occupation problems, and housing problems. Axis V: GAF-Current: 55; Estimated pre-injury: 85+. Recommendations: The initial evaluation that was completed suggested that the claimant would greatly benefit for a brief course of individual psychotherapeutic intervention using CBT approaches and basic self-management strategies coupled with autogenic exercises to facilitate a healthy adjustment and improve coping with their overall condition.

On December 30, 2011, performed a UR on the claimant. Rationale for Denial: The mechanism of injury was noted to include a head injury sustained on December 17, 2009. There was no detailed neuropsychological evaluation reviewed by either the designated doctor in this case or the counselor who is requesting psychological counseling services. A mental status examination provided evidence of 30/30 functioning but such an evaluation is not specific for assessment of concussion or head injury sequelae. The basis for an adequate treatment plan is an adequate evaluation. It is suggested that a neuropsychological evaluation be completed to determine if the patient has issues that need to be addressed from a neuropsychological perspective. Insufficient psychological evaluation was completed to determine the need for psychological treatment.

On January 13, 2012, submitted a request for reconsideration. In response to the denial it was written: His head is not considered a compensable part of his claim (Compensable: injury to lumbar strain, right shoulder strain, left knee contusion/strain, left ankle sprain & L5-S1 disc protrusions). So a neuropsychological evaluation would

not be approved. Clinician did a MMSE as part of our evaluation for patients that report a head injury. It was also documented that he had experienced a delayed recovery and had never participated in individual psychotherapy for his injury. It was recorded that he continues to take medication after 2 years after his injury and that he has attempted to cope by using pain medications and seems to have no tools necessary to manage pain without relying on medication.

On January 22, 2012, performed a UR on the claimant. Rationale for Denial: The clinical documentation provided indicated the patient was status post lumbar microdiscectomy, laminectomy, foraminotomy and partial facetectomy, and was status post left knee surgery. The clinical documentation provided indicated the patient continued with complaints of pain in the low back, left knee, right shoulder, and left ankle. The clinical documentation provided indicated the patient had signs and symptoms of anxiety and depression due to chronic pain. Guidelines recommend cognitive therapy with initial trial of 6 visits over 6 weeks and with evidence of objective functional improvement, a total of up to 13 to 20 visits over 13 to 20 weeks. The clinical documentation provided indicated the patient was noted to have signs and symptoms of anxiety and depression noted upon physical examination and the patient was noted to have undergone psychological testing which indicated the patient had severe depression and mild anxiety. The clinical documentation provided indicated the patient had been recommended for 6 sessions of individual psychotherapy on 04/15/10; however, there is lack of documentation provided indicating the number of visits of individual psychotherapy the patient had attended to date and the last date attended. As such, the request for individual psychotherapy sessions times 6 is non-certified.

On February 14, 2012, performed a UR on the claimant. Rationale for Denial: As per medical report dated 1-13-12, the patient had a fall injury sustaining injuries to his left ankle, left knee, right shoulder and back. He is exhibiting pain behaviors, fear avoidance and other psychosocial sequel such as sleep and mood issues which are interfering with his recovery. The patient describes the pain as a constant, severe stabbing pain which travels up his spine. There is also an achy and stabbing pain in his lower back. Upon review of the report, there is no clear documentation of exhaustive conservative treatment. The patient was noted to have undergone PT; however, there are no PT progress notes to show the patient's clinical and functional response. Moreover, optimized pharmacotherapeutic utilization in terms of VAS scoring is not evident in the report. As per referenced guideline, initial therapy for these "at risk" patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT. With these, the need for the request is not substantiated at this time.

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

The previous adverse determinations are upheld. Based on the records provided for review, there is not enough documentation that lower conservative treatment has been exhausted. It was documented that the claimant received physical therapy prior to undergoing back surgery and left knee surgery, however, no PT progress notes were

provided to determine his response to the PT. Furthermore, it was reported in the documentation that following surgery, the claimant did not receive physical therapy. According to ODG, "Initial therapy for these "at risk" patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:" Since the claimant did not receive post-operative PT and there is a lack of documented progress or lack thereof, the request for Individual Psychotherapy Sessions x6 90806 Left Ankle, Left Knee, Rt. Shoulder, Back is denied.

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). (Kröner-Herwig, 2009) See the Low Back Chapter, "Behavioral treatment", and the Stress/Mental Chapter. See also Multi-disciplinary pain programs.</p> <p>ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ).</p> <p>Initial therapy for these "at risk" patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT.</p> <p>Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:</p> <ul style="list-style-type: none"> - 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) <p>With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG Mental/Stress Chapter, repeated below.</p> <p>ODG Psychotherapy Guidelines:</p> <ul style="list-style-type: none"> - Initial trial of 6 visits over 6 weeks - With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions) <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. (Leichsenring, 2008)</p>
Psychological treatment	<p>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:</p> <p>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.</p> <p>Step 2: Identify patients who continue to experience pain and disability after the usual</p>

	<p>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.</p> <p>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)</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)**