

Notice of Independent Review Decision

DATE OF REVIEW: July 14, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Psychotherapy 1 x 4 weeks and Biofeedback Therapy 1 x 4 weeks (EMG, PNG, TEMP)

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

The reviewer is a licensed Psychologist with expertise in chronic pain and traumatic brain injuries, a Diplomate of the American Board of Pain Management and recognized by National Register of Health Service Providers in Psychology. The reviewer has been licensed in the State of Texas since 2000.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
Psychological Intake and Evaluation	12/26/2013
Initial Rehab Evaluation	01/20/2014
Individual Psychotherapy Treatment	02/25/2014 and 04/23/2014
Progress Report	03/15/2014
Re-evaluation Injury Report	04/16/2014
Preauthorization request	05/22/2014
An initial adverse determination	05/27/2014
A denial letter	05/29/2014
Reconsideration of preauthorization request	06/02/2014
A reconsideration of adverse determination	06/17/2014



**MEDICAL EVALUATORS
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by	
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EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female who sustained work-related injury to her right ankle on xx/xx/xx while she was walking down some stairs and twisted her right foot/ankle. She initially had a right foot MRI that showed calcaneal cuboid bone fragment with degenerative changes as well as osteophytes and cystic changes indicating perhaps old fracture. She then had right foot surgery on 11/01/2013 with removal of the nonunion fragment. Subsequently, she continued to have pain in her right foot with difficulty falling sleep secondary to pain. On 12/16/2013, she had a psychological evaluation on 12/16/2013 who noted due to her injury, her activities of daily living have been interrupted and she is having difficulty with household chores, cooking, sports, and exercise. She reported she is unable to drive for no more than 10 minutes and sit for no more than 10 minutes. The patient rated her overall function prior to the injury at 96% and after the injury at 40%. On mental status exam, her memory for both recent and remote events was intact. Her judgment, insight and impulse control were fair. Based on Beck Depression Inventory and the Beck Anxiety Inventory, the patient scored a 42 on the DKI-II, indicating severe depression. The patient's score on the BAI was 40, indicating severe anxiety. She showed significant fear/avoidance of work on the FABQ test. She was recommended 6 sessions of IPT therapy.

On 04/23/2014, the patient returned for a re-assessment of her individual psychotherapy treatment. She was noted to have completed 8 individual therapy sessions and 2 biofeedback sessions. She was noted to have a positive response to treatment. The patient was noted to be in compliance with prescribed treatment and successful improvements were evident. She was noted to show progression in sessions and at home with reducing negative symptoms utilizing relaxation techniques and abdominal breathing. It was noted that although she is progressing with her treatment, she still exhibits moderate to severe deficits. It was noted that the patient is abstaining from smoking without the assistance of medications such as Chantix to help alleviate symptoms of withdrawal or anxiety. She was diagnosed with somatic symptom disorder, with predominant pain, acute, moderate; major depression disorder, single episode, severe without psychotic features; and unspecified anxiety disorder. She was recommended individual psychotherapy and concurrent biofeedback to improve stress, reductions in level of muscle tension, and better sleep. The request for Individual Psychotherapy 1 x 4 weeks and Biofeedback Therapy 1 x 4 weeks (EMG, PNG, TEMP) is non-certified as there was no specific information provided to determine the patient's return to work status neither were there specific functional goals provided that would aid in the determination of the patient's return to work status.

Physical Medicine reviewed the stated request on 05/29/2014 for medical necessity. stated Ms. reported her level of pain at 9/10, on a scale of 0 to 10, with higher numbers



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indicating greater perceived intensity levels, according to Individual Psychotherapy Treatment (IPT) on 04123/2014. also stated he reviewed patient's pre-1PT symptoms and stated the patient reported her pain rating as 10/10, with irritability at 10/10, frustration at 10/10, muscle tension at 9/10, and anxiety at 10/10 all on a scale of 0 to 10 with greater numbers indicating greater pain or distress. The patient also endorsed symptoms on the Beck Anxiety Inventory (BAI) that were in the severe range and also endorsed symptoms considered severe on the Beck Depression Inventory (BAI) 11 with sleep problems. The patient was currently abstaining from smoking, and was not taking any medications to help alleviate anxiety and withdrawal. The patient was applying coping skills and response was positive. Compliance was demonstrated for the prescribed treatment and successful improvements were evident. The patient had shown progress in session and at home with reducing negative symptoms through utilization of relaxation techniques and abdominal breathing. The patient had improved ability to cope with pain and limited mobility. Patient had implemented a wider range of coping mechanisms including improved social relations, relaxation techniques, and self-hypnosis to good effect and reduction of negative symptoms. While the patient showed some moderate improvements at reducing negative symptoms, there still exhibited some moderate to severe deficits. The patient was currently 21 days tobacco free. The patient was diagnosed with Somatic Symptom Disorder, with predominant pain, Acute, Moderate (300.82), Major Depressive Disorder, Single Episode, Severe without psychotic features (296.23), and Unspecified Anxiety Disorder (300.00). The patient also had a diagnosis of Fracture of calcaneus, closed (825.0), and sprain of the ankle (845.00). This was a review for the medical necessity of individual psychotherapy 1x week x4 weeks 90837 – Psychotherapy, 60 minutes with patient and/or family member, biofeedback therapy 1 x week x 4 weeks 90901 - Biofeedback training by any modality.

Using Official Disability Guidelines as a criteria for reviewing progress and the fact the patient completed 8 IPT and 2 biofeedback session, determined the request to not be medically reasonable or necessary. He based his decision on the data that "no clear detail was provided as to what specific functional goals are in place, including whether a return back to work is planned or not."

On First Appeal 06/17/2014, upheld the previous decision of non-certification for the requested treatment. stated "Per telephonic consultation (treatment provider team), the patient presents with very severe reports of depression and anxiety; however, she has not been assessed for psychotropic medications. Current evidence based guidelines note that the gold standard of treatment is a combination of individual psychotherapy and medication management. There are no objective indications of improvement, only subjective reports."

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



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Patient is female who presented to therapist on 12/16/2013 with a diagnosis of somatic symptom disorder, with pre-dominant pain, acute; major depressive disorder, single episode, severe without psychotic features and unspecified anxiety disorder. Patient suffered an industrial accident on 08/07/2013. MOI concerns falling out of a chair, while performing her usual and customary services at her job. The patient sustained an injury to her right ankle (requiring surgery) for which she has received rehabilitation. Patient reported problems with her activities of daily living and she is having difficulty with household chores, cooking, sports, and exercise. She reported she is unable to drive for no more than 10 minutes and sit for no more than 10 minutes. The patient has been surgically and conservatively treated. She has completed most sessions of PT, 8 sessions of individual psychotherapy, and 2 sessions of biofeedback therapy. Medical records note significant improvement that is documented quantitatively in reports. Reviewer have non-certified request of additional 4 sessions on individual psychotherapy once a week with 4 sessions of biofeedback therapy for 4 weeks due to the following: no objective report of improvement only subjective, no indication of how or when patient will return to work, and no evaluation for psychotropic medication. The request for biofeedback therapy in conjunction with individual psychotherapy was an appropriate recommendation according to ODG guidelines. There is documentation of symptom improvement that is presented as quantitatively as can be. Pain is a subjective phenomenon that requires total input from the patient. In other words, if the patient states they are in pain, they are! Although there is no stated return to work plan documented, the providers are doing the same with treatment. Even with a plan treatment must sometimes be dynamic and be able to change when necessary based on patient's gains/loss, resources, and emotional sequelae. With the patient only completing 8 sessions of individual psychotherapy and 2 sessions of biofeedback there still remains time to concrete a return to work plan. However, medical records noted patient's employer contacted patient and stated because of physical limitation the company had no present work for her. The providers are incorporating this into a current treatment plan as well. Although psychotropic medication and individual psychotherapy is considered best practice from the mental health literature and current medical practice it is not always the best treatment for the patient. The patient can still make a choice not to take medication without being non-compliant.

Given the information received in medical records, the two past reviews, and the ODG criteria, I am recommending the adverse determination be overturned as I find that the request for continued treatment is medically needed and necessary for continuity of treatment. There was also a delay in patient receiving treatment, which could make her viewed as an outlier.

The Official Disability Guidelines (ODG), Treatment Index, 13th edition (web), 2014, Pain

- Psychological Treatment states treatment is "Recommended for appropriately identified



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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."

The Official Disability Guidelines (ODG), Treatment Index, 13th edition (web), 2014, Pain - Behavioral Interventions states "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.

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) in the Low Back Chapter.

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:

- 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)

With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG Mental/Stress Chapter, repeated below.

ODG Psychotherapy Guidelines:



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- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)

- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.

See Number of psychotherapy sessions for more information.

ODG – Pain (Chronic)

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:



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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

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)