

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 5, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Medical Biofeedback, 90836 X 12 sessions, 90901 X 12 sessions, 90853 X 12 sessions

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

This case was reviewed by a PhD licensed by the Texas State Board. The reviewer specializes in Clinical psychology; Member American Academy of Pain Management and is engaged in full time practice.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
924.11, 959.01	90836		Prosp	12			Xx/xx/xx	xxxxx	Upheld
924.11, 959.01	90901		Prosp	12			Xx/xx/xx	xxxxx	Upheld
924.11, 959.01	90853		Prosp	12			Xx/xx/xx	xxxxx	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-20 pages

Respondent records- a total of 117 pages of records received to include but not limited to: DOS 12.13.13; letter 8.20.13, 11.26.13, 2.27.14; DDE report 9.11.13, 12.13.13; letter 1.16.14, 1.30.14; Medical Review report 1.16.14, 1.30.14; Reconsideration request 1.24.14; Specific and Subsequent Medical Report 8.13.13; Law; records 8.6.13-8.13.13; ODG TWC Integrated Treatment/Disability Duration Guide; BDI-II Beck Depression Inventory II, Interpretive Report; Request for an RME form; Preauthorization request 1.10.14; Request for an IRO forms

Requestor records- a total of 0 pages of records received to include but not limited to:
2.27.14-Sent Notice of IRO assignment; 3.3.14-received letter office requesting IRO be dismissed; No official withdrawal received from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured at work on xx/xx/xx. At the time, records indicate he was performing his usual job duties. that resulted in patient falling, leading to head and right knee injuries. Patient established treating and on 8-6-13, a PPA/ baseline biofeedback study was conducted. Treatment plan, based on MHTG, was for 24 initial biofeedback sessions.

On 1-21-14, mental status exam and psychological testing revealed patient rated his average pain level at 6-8/10, and scored 21 on the BDI, placing him in the moderate range of depression. He was diagnosed with 309.81 PTSD, with severe depressive symptoms. On 1-16-14, a concurrent request for 12 biofeedback sessions were denied through peer review. Goals are to employ biofeedback and relaxation techniques to decrease pain, anxiety and depression, and to improve sleep.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

Patient has been evaluated and diagnosed with PTSD and depression, which would normally lead one to seek approval for individual therapy. However, treatment in this case remains focused on copious amounts of biofeedback, which will not cure PTSD or depression, and is therefore, not recommended as a stand-alone treatment. A stepped-care approach to treatment has not been followed, as per ODG, and the previously requested biofeedback sessions do not follow ODG.

ODG Work Loss Data, Texas

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) (Altmair, 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

Cognitive Behavioral therapy for PTSD:

Recommended. There is evidence that individual Trauma-focused cognitive behavioral therapy/exposure therapy (TFCBT), stress management and group TFCBT are very effective in the treatment of post-traumatic stress disorder (PTSD). Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There was some evidence that individual TFCBT is superior to stress management in the treatment of PTSD at between 2 and 5 months following treatment, and also that TFCBT was also more effective than other therapies. (Bisson, 2007) (Deville, 1999) (Foa, 1997) (Foa, 2006) Cognitive therapy is an effective intervention for recent-onset PTSD. (Ehlers, 2003) Empirical research has demonstrated consistently that Cognitive Behavioral Therapy (CBT) is supported for the treatment of PTSD. It has been demonstrated that CBT is more effective than self-help, de-briefing, or supportive therapy in preventing more entrenched PTSD symptoms. Importantly, it is unclear if supportive therapy was of any clinical value in the treatment of PTSD since it appeared to impede psychological recovery. Strengths of CBT is difference in the safety and efficacy of providing treatment, working through traumatic memories, and helping the person through to re-frame one's interpretations of both the event and PTSD symptoms. Most importantly, CBT tended to have no to few side effects, unlike medications and could be employed efficiently for acute symptom treatment. (Warren, 2005) Cognitive Therapy (CT) is effective with civilian men and women exposed to combat and noncombat trauma. (VA/DoD, 2004) (Lovell, 2001) (Marks, 1998) CT is effective for women with PTSD associated with sexual assault. (Resick, 2002) Cognitive behavior programs, including exposure therapy, are currently the treatment of choice for PTSD. (Botella, 2009) The AHRQ study concluded that cognitive processing therapy has moderate evidence supporting efficacy for improving some outcomes for adults with PTSD, whereas the IOM report did not make a specific conclusion about cognitive processing therapy. (Jonas, 2013) See also PTSD psychotherapy interventions.

ODG Psychotherapy Guidelines:

- 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)

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)

Cognitive therapy for depression:

Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (Gloaguen, 1998) In

another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. (Pampallona, 2004) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (Royal Australian, 2003) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (Warren, 2005) Delivering cognitive behavioral therapy (CBT) by telephone is as effective as delivering it face-to-face in the short term, and telephone therapy is safe and has a higher patient retention rate. The attrition rate from psychotherapy can exceed 50% due to time constraints, lack of available and accessible services, transportation problems, and cost. Significantly fewer participants receiving telephone CBT discontinued their therapy than did those receiving face-to-face CBT. Both treatment groups showed significant improvement in depression, and there were no significant treatment differences when measured at post treatment between telephone and face-to-face CBT. However, face-to-face CBT was significantly superior to telephone CBT during the follow-up period. The RCT used 18 sessions of either telephone CBT or face-to-face CBT. (Mohr, 2012) Maintenance cognitive-behavioral therapy (CBT) to prevent recurrent depression is most effective in patients at highest risk for relapse, defined as those with 5 or more previous depressive episodes. For individuals at more moderate risk for recurrence (fewer than 5 prior episodes), structured patient psycho education may be equally effective. High-risk patients in particular may benefit from specific elements of maintenance CBT by reducing cognitive vulnerability factors for recurrent depression, such as ruminating, negative attributions and memories, and dysfunctional beliefs, or by maintaining positive emotions when experiencing stress. (Stangier, 2013) See also Bibliotherapy. Psychotherapy visits are generally separate from physical therapy visits.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES