

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** September 4, 2014

**IRO CASE #:**

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

Individual Psychotherapy 1 x Wk x 4 Wks 90837

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

The reviewer is certified by the American Board of Family Medicine with over 14 years of experience.

**REVIEW OUTCOME:**

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who injured her left upper extremity on xx/xx/xx.

08/08/13: The claimant was evaluated. She reported her injury as occurring on xx/xx/xx. She completed 40 sessions of PT following the injury and received one ESI. It was noted that injection had some positive effects on her pain. Her medications at the time of this visit included cyclobenzaprine, gabapentin, hydrocodone, and Nortriptyline. She rated her pain as a 1/10 and described the pain as being a constant stabbing and aching in her hand and arm. On exam, her BDI-II score was 22 indicating moderate depression. Her BAI score was 15 reflecting mild anxiety. Her FABQ score showed significant fear avoidance of work (FABQ-W 32) as well as non-significant fear avoidance of physical activity in general (FABQ-PA 12). She was diagnosed with major depressive disorder, single episode, moderate and pain disorder associated with both psychological factors and a general medical condition, chronic. It was recommended that she be referred for psychotropic consultation and 4 sessions of IPT therapy.

08/22/13: The claimant was evaluated for MMI. Her chief complaint at that time was left upper extremity pain, weakness, and diminished sensation. She was working at light duty. noted that left wrist x-rays dated 12/26/12 were negative and left wrist MRI dated 01/15/13 showed marrow edema within the proximal 2<sup>nd</sup> and 3<sup>rd</sup> metacarpals most consistent with bone marrow contusions. No fracture. Small 5 mm ganglion cyst. On exam of the right-hand dominant female, she had mild crepitus in the left wrist with movement. Tinel's, Phalen's, and Finklestein's tests were positive at the left wrist. 4/5 strength in the left grip. Hypersensitivity in the C5-T1 dermatomes on the left. Reflexes were 2+ at triceps and brachioradialis. Biceps were 1+. Hoffman's was negative. assessment was that she had not reached maximal medical improvement and required further rehabilitation.

09/19/13: Operative Report. POSTOPERATIVE DIAGNOSIS: RSD LUE.  
PROCEDURE: Stellate ganglion block, left.

09/26/13: The claimant was evaluated. It was noted that Neurontin had caused a significant weight gain, Nortriptyline had not helped her sleep, Lyrica was causing emotional instability, and Flexeril was on longer helping. Her current medications included hydrocodone, Flexeril, Ambien, and Elavil. It was noted that she received 95% improvement for more than two weeks following left stellate ganglion block performed on 03/28/13. She was noted to be in PT but had not tried a TENS unit. On neurologic exam, she was alert and oriented x 3. DTRs were 2+. She had normal sensation throughout. Gait was normal. She had 5/5 strength throughout. Assessment: Chronic pain syndrome. RSD of the left upper extremity. Muscle spasms. Use of high-risk medications, Insomnia. Plan: Continue Zanaflex, Elavil, hydrocodone, and Ambien.

11/09/13: The claimant was evaluated for continued left upper extremity pain. It was noted that she seemed quite unhappy in general. Her medications included gabapentin, hydrocodone, Tizanidine, and Zolpidem. IMPRESSION: LUE strain, cervical strain, possible RSD, major depressive disorder. PLAN: Continue with counseling. Order FCE. Request work hardening program. Return to work without restrictions. Follow up in one month.

04/15/14: A pre-authorization request for Work Hardening Program indicates that the claimant had completed 40 sessions of PT, stellate ganglion injection, and 4 sessions of individual psychotherapy. EMG on 01/30/14 reportedly showed clinical evidence of complex regional pain syndrome and post-traumatic left cubital tunnel.

04/17/14: Examination revealed that the claimant had not reached maximal medical improvement

04/29/14: Work hardening daily note indicated that the claimant was in her 6<sup>th</sup> session or 48 hours of the Work Hardening Program. She reported her pain level to be 8/10. She had stated that her pain had increased in her hand and shoulder.

She was able to complete the required exercises but the pain increased when she performed them.

On 05/06/14: A physical performance evaluation was performed who recommended a psychological evaluation for her emotional complications as a result of her injury.

05/07/14: A note indicated that the claimant had made appreciable gains in the short time she had been in the work hardening program. She had decreased her fear of physical activity and some of her depressive symptoms. She had decreased her irritability, frustration, muscle tension, and pain through the use of pacing and relaxation techniques that she had learned while in the program. It was noted that she personally stated that she felt she had more strength and endurance. However, she had not met her PDL and could not be safely returned to full duty at that time. Additional program was recommended so that she could return to full duty work. Her medications at that time included gabapentin, hydrocodone, Tizanidine, Tramadol, and Zolpidem. It was noted that her hydrocodone had been titrated by 40% and Tramadol by 33%. She was diagnosed with major depressive disorder, single episode, moderate and somatic symptom disorder, with predominant pain, persistent, moderate. It was recommended that she continue with the work hardening program.

05/14/14: The claimant was evaluated. She rated her pain as 8/10 without meds and 6/10 with meds. She stated that her pain was better than at previous visit and that previous injection in February was helpful. She was using a TENS unit and attending work hardening program which she stated was helpful. The plan was to schedule repeat left ganglion block and follow up in 30 days.

06/03/14: A note noted that the claimant had made some gains in WH. She was encouraged to continue implementing what she learned in the program and to engage in a home exercise plan. It was recommended that she attend 4 more IND sessions to address the increasing anxiety and depression related to the work injury. She was referred back to her treating doctor for follow-up management of her medical care as needed.

06/30/14: The claimant was evaluated by FNP for left upper extremity pain. She was noted to feel depressed and frustrated with coping with the pain. It was noted that the pain prevented her from taking part in social activities or recreational activities. It was noted that she had had multiple stellate ganglion blocks in 2013 that reduced her pain for weeks dramatically. She was to undergo additional block.

07/07/14: UR. RATIONALE: ODG do recommend cognitive behavioral therapy for patients who are at risk for delayed recovery. The clinical documentation submitted for review does indicate that the patient is participating in a work hardening program. The results of that program with documentation of remaining functional deficits that could be addressed in individual therapy would need to be addressed prior to determination of continued individual treatment outside the

work hardening program. As such, the requested individual psychotherapy 1 time a week for four weeks 90837 is not medically necessary or appropriate.

07/23/14: A note indicates that the claimant completed 20 days of WH, but the treatment team “agreed that she presents with increased depression and anxiety after completion of the program.” A table was documented indicating that the claimant’s depression had stayed the same throughout the program, and her BAI increased from 10 to 20. It was noted that they were “requesting four sessions to address her mood/pain complaints and ensure that these barriers do not affect her ability to return to work successfully.”

07/31/14: UR. RATIONALE: The patient had 5 sessions of individual psychotherapy in September 2013 and did not have a good response per the provider. The patient had an organic pain generator that had not been addressed at that time, and with appropriate therapy for her pain generator and group counseling/psychotherapy as a part of a work hardening program, her BDI, BAI, and anxiety/depression self-report, as well as pain reporting, are not substantially improved. Therefore, it is unlikely that the patient is going to benefit from the individual psychotherapy again. The patient’s “organic pain generator” has been addressed with hydrocodone and other therapies without benefit in psychological terms. Further, the patient was recommended to have a trial of an antidepressant by her psychologist in 2013. This was never done. If the patient fails medication therapy, or as an adjunct to that therapy, one could consider individual psychotherapy down the line. At this time, individual psychotherapy is not warranted.

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

The previous adverse decisions are overturned. The claimant suffered a significant mechanical injury to her left upper extremity in xx/xxxx. Since that time, she has undergone multiple medical procedures, stellate ganglion blocks, physical therapy, work hardening, and required multiple medications, many of which are psychoactive. It is quite common for individuals with prolonged recoveries and chronic pain to suffer from adjustment disorder, major depression, anxiety, and chronic pain syndrome. The claimant was indeed seen initially in September 2013 in individual psychotherapy. However, it is reported that she “did not have a good response.” This is not a basis for rationale that she would not have a therapeutic response at another time with another therapist. She again attended therapy in May 2014-June 2014 for a period of 8 weekly sessions and appears to have had a somewhat more positive response with “decreased irritability, frustration and pain.” She reduced the use of her psychoactive pain medications and improved during her Work Hardening Program. As she completed her program, the patient’s anxiety increased, which is not surprising. The team requests four additional sessions to address her mood as she transitions back to work. Continued psychotherapy would be warranted in a patient who has been out of work for more than a year due to injury. The ODG for psychological treatment recommend 13-20 visits over 7-20 weeks for cases of severe depression. I believe the claimant has exhibited signs and symptoms that would qualify her as

moderate to severe depression. She would also likely benefit from a trial of anti-depressant therapy, as recommended in the Multi-disciplinary Pain Program. If the claimant is having even slight progress in psychotherapy, it is only in her best interest to continue it as she transitions back to work. Therefore, the request for Individual Psychotherapy 1 x Wk x 4 Wks 90837 is found to meet the ODG criteria and is medically necessary.

**ODG:**

<p>Psychological treatment</p>	<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><u>Step 1:</u> 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><u>Step 2:</u> 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.</p> <p><u>Step 3:</u> 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 <a href="#">Multi-disciplinary pain programs</a>. See also <a href="#">ODG Cognitive Behavioral Therapy (CBT) Guidelines</a>. (<a href="#">Otis, 2006</a>) (<a href="#">Townsend, 2006</a>) (<a href="#">Kerns, 2005</a>) (<a href="#">Flor, 1992</a>) (<a href="#">Morley, 1999</a>) (<a href="#">Ostelo, 2005</a>) See also <a href="#">Psychosocial adjunctive methods</a> in the Mental Illness &amp; Stress Chapter. Several recent reviews support the assertion of efficacy of cognitive-behavioral therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). (<a href="#">Kröner-Herwig, 2009</a>)</p>
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<p>Behavioral interventions</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 (FABQ)</a> in the Low Back Chapter. 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:  - Initial trial of 3-4 psychotherapy visits over 2 weeks  - With evidence of objective <a href="#">functional improvement</a>, 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 <a href="#">Mental/Stress Chapter</a>, repeated below.  <b>ODG Psychotherapy Guidelines:</b>  - 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</p>
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	being made. See <a href="#">Number of psychotherapy sessions</a> for more information.
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Cognitive therapy for depression	<b>ODG Psychotherapy Guidelines:</b> - 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.
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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)**