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Notice of Independent Review Decision

Date notice sent to all parties: 09/10/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Six sessions of individual psychotherapy

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

Licensed by the Texas State Board of Examiners of Psychologists

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)

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

Six sessions of individual psychotherapy - Overturned

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 06/28/14, recommended a psychological evaluation to include an intake, individual counseling, biofeedback, testing, and treatment. provided an Updated

Behavioral Medicine Assessment on 07/02/14. She injured her buttocks, low back, and hip on xx/xx/xx. She slipped on some ice on the floor and landed on her buttocks. As she was leaving to go to the company doctor, she was rear-ended by a company vehicle, which resulted in head, neck, and right shoulder pain. The MVA was considered a separate work injury. Lumbar MRIs were performed on 08/05/10 and 09/15/10. A brain MRI dated 02/10/10 was normal. She also received ESIs to the lumbar and cervical spine. She had received six sessions of individual therapy and 20 sessions of a chronic pain management program. It was noted she had been referred to pain management several times, but it had been denied. had requested additional psychotherapy to address her continued chronic pain, depression, and emotional instability. Her present medications were Flexeril, Lyrica, Motrin, Topamax, and Tramadol. Her primary pain was in the lower back and neck. Her symptoms had a negative impact on a wide range of functions. The patient rated her current level of functioning at 50%. Her mood was dysthymic while her affect was constricted. It was felt she endorsed fear avoidance of both physical activity in general, as well as work. Her baseline BDI II was 19 and her BAI baseline was 24. Her pain, frustration, muscle tension, and anxiety were rated 6/10 and irritability and depression were rated at 5/10. The diagnoses were major depressive disorder, single episode, moderate, and somatic symptom disorder, with prominent pain, persistent, moderate. It was felt the patient was an excellent candidate for six individual sessions. On 07/30/14, provided a preauthorization request for individual psychotherapy once a week for six weeks. On 08/05/14, provided an adverse determination for the requested six sessions of individual psychotherapy. On 08/12/14, provided a reconsideration preauthorization request for the individual psychotherapy once a week for six weeks. It was felt the request should be reviewed by a psychologist or a psychiatrist. Her progress made in the chronic pain program was reviewed. Her pain improved 12.5%, but her irritability declined 16.67%. Her frustration did not improve, but her muscle tension improved 87.5%. Her anxiety improved 22.22% and her depression improved 12.5%. It was noted the goal was to do the sessions and they would try to help the patient locate a community referral for medication and possible psychotherapy. She would be given a referral for employment assistance if it had not already been done. It was felt she met the ODG criteria for the individual psychotherapy sessions under the Mental Illness Stress Chapter. The goals of the psychotherapy were reiterated. On 08/18/14, provided another adverse determination for the requested six sessions of individual psychotherapy.

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

Even though the patient went through counseling and a chronic pain management program in 2012, she has recently resumed treatment for chronic pain. Due to said chronic pain, she reports experiencing mild to moderate depression and anxiety symptoms and was diagnosed with major depression. The ODG psychotherapy step care guidelines for pain include the identification of 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, further treatment options, including brief individual or group therapy.” The patient’s return to therapy following a lengthy hiatus is considered evidence that she continues to experience pain after the usual time of recovery. Additionally, the assertion that psychotherapy would be of limited utility does not seem supported by the research cited in the ODG regarding efficacy of cognitive behavioral therapy. The ODG 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 and physical dependence. Several recent reviews support assertion of efficacy of cognitive behavioral therapy in the treatment of pain.” (Croner-Herwig 2009)

The ODG cognitive behavioral guidelines for chronic pain include an initial trial of three to four psychotherapy visits over two weeks. With evidence of objective functional improvement, a total of up to six to ten visits over five to six weeks of individual sessions is noted to be appropriate. The ODG psychotherapy guidelines state an initial trial of six visits over six weeks if progress is made. The ODG psychology guidelines for pain recommended for appropriately identified patients during treatment for chronic pain, psychological intervention for chronic pain, include setting goals, determining appropriateness of treatment, conceptualizing the patient’s pain beliefs and coping style, assessing psychological and cognitive functioning, 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 is found to have a positive short term effect on pain interference and long term effect on return to work.

The following step care approach to pain management that involves psychological intervention has been suggested. Step one: 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 and how to screen for patients that may need early psychological intervention. Step two: Identify patients that 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 three: Pain is sustained in spite of continued therapy, including the above psychological care. Intensive care may be required from mental health professionals, allowing for a multi-disciplinary treatment approach. (See also multi-disciplinary pain program.) The patient is identified as a patient who continues to experience pain and disability after the usual time of recovery, as outlined in step two above, due to her recent diagnosis of major depressive disorder and moderate anxiety symptoms, as well as difficulty managing pain six years after the date of injury. Therefore, the requested six sessions of individual therapy are reasonable, medically necessary, and within the criteria of the ODG and the previous adverse determinations should be overturned at this time.

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)**

ODG cognitive behavioral therapy, CBT guidelines, Otis 2006, Townsend 2006, Currens 2005, Floor 1992, Marley 1999, Ostello 2005. See also psychosocial adjunctive methods in the mental illness and stress chapter.

Several recent reviews support the assertion of efficacy of cognitive behavioral therapy in the treatment of pain, especially chronic back pain, Crono and Herd 2009.