



# PROFESSIONAL ASSOCIATES

## NOTICE OF INDEPENDENT REVIEW

**NAME OF PATIENT:**  
**IRO CASE NUMBER:** M2-05-2272-01  
**NAME OF REQUESTOR:** Texas Health  
**NAME OF PROVIDER:** Robert Ippolito, M.D.  
**REVIEWED BY:** Board Certified in Psychiatry  
Board Certified in Neurology in Psychiatry  
Board Certified in Pain Medicine  
**IRO CERTIFICATION NO:** IRO 5288  
**DATE OF REPORT:** 09/26/05

Dear Texas Health:

Professional Associates has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO) (#IRO5288). Texas Insurance Code Article 21.58C, effective September 1, 1997, allows a patient, in the event of a life-threatening condition or after having completed the utilization review agent's internal process, to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TDI-Division of Workers' Compensation (DWC) to randomly assign cases to IROs, DWC has assigned your case to Professional Associates for an independent review. The reviewing physician selected has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, the reviewing physician reviewed relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal. determination, and any documentation and written information submitted in support of the appeal.

This case was reviewed by a physician reviewer who is Board Certified in the area of Psychiatry, Neurology in Psychiatry, and Pain Medicine and is currently listed on the TWCC Approved Doctor List.

**M2-05-2272-01**

**Page Two**

I am the Secretary and General Counsel of Professional Associates and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for determination prior to referral to the Independent Review Organization.

### **REVIEWER REPORT**

#### **Information Provided for Review:**

Evaluations with William J. Anderson, M.D., a hand surgeon, dated 03/16/94, 03/23/94, 03/28/94, 04/13/94, 06/10/94, 06/15/94, 07/06/94, 07/13/94, 08/15/94, 09/07/94, 10/31/94, 11/23/94, 12/12/94, 03/22/95, 04/19/95, 05/08/95, and 09/04/96  
EMG/NCV studies interpreted by R. Frank Morrison, M.D. dated 04/11/9 and 03/18/05  
An evaluation with Brady G. Giesler, M.D. dated 06/30/94  
An oncology evaluation with Dawn Klemow, M.D. dated 07/11/94  
An evaluation by Azad V. Bhatt, M.D. on 02/20/95  
An evaluation with David R. Webb, Jr., M.D. dated 10/21/96  
An evaluation with J.A. Coffey, Jr., M.D. dated 02/11/97  
A pain management evaluation with Tim Zoys, M.D. dated 08/25/97  
A behavioral medicine evaluation with Martin Deschner, Ph.D. on 10/01/97  
A letter written to the claimant by Dr. Zoys dated 10/03/97  
A pain management evaluation with Carl Noe, M.D. on 05/15/98  
An evaluation by Mohammad Tariq, M.D. dated 08/17/99  
A letter from Jackie R. Norris, M.D. dated 10/19/00  
An orthopedic evaluation by Kent F. Dickson, M.D. dated 11/14/00  
A rehabilitation evaluation by Richard R. Jones, M.D. dated 11/28/00  
A letter written by Don A. Smith, Ph.D. on 05/31/01  
An EMG/NCV study interpreted by Jayaraman Ravindran, M.D. dated 06/28/02  
Evaluations by Dr. Norris on 10/23/02, 12/02/02, 02/04/03, 03/28/03, 05/09/03, 06/27/03, 07/28/03, and 08/28/03  
A physical therapy evaluation by Beth M. Cox, O.T.R. on 01/13/03  
A discharge summary from Roxane Brown, L.C.D.C. dated 06/23/03  
Evaluations by R. Robert Ippolito, M.D. dated 02/01/05, 02/22/05, 03/01/05, 03/08/05, 03/15/05, 03/29/05, 04/12/05, 04/26/05, 05/10/05, 05/24/05, 06/07/05, 06/21/05, and 07/05/05  
An MRI of the wrist and hand on 03/07/05 interpreted by Rudolph H. Miller, III, M.D.

**M2-05-2272-01**

**Page Three**

An EMG/NCV study interpreted by Erwin A. Cruz, M.D. dated 03/10/05

A behavioral medicine consultation with Tracey Duran, M.S., L.P.C. dated 04/07/05

Letters of non-authorization for psychotherapy sessions from Liberty Mutual Group dated 06/15/05 and 07/13/05

Letters of non-authorization for biofeedback training from Liberty Mutual Group dated 06/17/05 and 07/13/05

A reconsideration request for behavioral health treatment by Ms. Duran dated 07/05/05

A requestor's position on pre-authorization from Nicole Mangum, Ph.D. and Jeanne Selby, Ph.D. dated 08/08/05

A letter to the medical dispute resolution department of the Texas Workers Compensation Commission (TWCC) from Carolyn Guard, R.N.C. dated 08/16/05

**Clinical History Summarized:**

The patient in question was injured on \_\_\_\_\_. The patient developed wrist pain. She apparently had a cyst that was drained. The patient was eventually diagnosed with carpal tunnel syndrome and went through extensive medical management including surgery, medications, and psychological treatment. She apparently developed complex regional pain syndrome on the right upper extremity. She eventually developed what appears to be chemical dependency. The patient was evaluated on 03/07/04 at Texas health. Apparently this was by Licensed Professional Counselor (LPC) Tracey Duran. She diagnosed a pain disorder and a possible major depressive disorder. However, in an appeal letter dated 08/08/05 Dr. Mangum and Dr. Shelby document that the patient was detoxed from opiates back in 2003 inferring the diagnosis of opiate dependency. There is a request for individual psychotherapy and biofeedback; however there is no documentation in the evaluation of participation in 12-step program, having a sponsor, and actively working a recovery program.

**Disputed Services:**

Four sessions of psychotherapy with psychophysiological assessment and biofeedback

**Decision:**

I disagree with the requestor. The four sessions of psychotherapy with psychophysiological assessment and biofeedback would not be reasonable or necessary.

**Rationale/Basis for Decision:**

The patient had what appears to be a ganglion cyst and carpal tunnel syndrome. After extensive treatment, high-dose opiate use, opiate detoxification, the patient continues to have pain complaints. Evidenced-based guidelines do not support unimodal psychotherapy with or without biofeedback for pain complaints. American College of Occupational and Environmental Guidelines (ACOEM) chapter 6, page 107, reads: "The immediate focus should be on functional improvement rather than on abolishing pain. Physicians should be aware that while complete cessation of pain may not be a realistic goal for some patients, self-care, functional restoration, and successful reintegration into the workforce can be attainable goals even though the complete elimination of pain may not be possible." There are many dimensions to pain. A major dimension of chronic pain complaints is fear avoidance as a result of a fear of reinjury. Pain related to fear avoidance models typically describe these chronic pain patients as perpetuating disability, and ACOEM chapter 6, page 113 reads "Exposing patients to activities they fear as a way to reduce their pain-related fear can be a powerful intervention for chronic pain. A decline in pain related fear may reduce pain vigilance, resulting in a decline in reported pain intensity." The proposed individual psychotherapy would not provide in vivo exposure to feared activities that purportedly generate pain. A recent randomized clinical trial to support a combination of psychotherapy and physical therapy for low back pain. A trial of an activating intervention for chronic back pain in primary care and physical therapy settings. Michael Von Korffa, Benjamin H.K. Baldersona, Kathleen Saunders, Diana L. Miglioretia, Elizabeth H.B. Lina, Stephen Berryb, James E. Moorec and Judith A. Turnerd. Pain. 2005 Feb;113(3):323-30. However, this was in a cohort of motivated group health patients. For the patient's with disability status, the treatment was not helpful.

Evidence based guidelines and research also do not support biofeedback for this type of pain complaint.

The literature generally supports biofeedback as efficacious for the following conditions:

1. Urinary incontinence
2. Migraine and tension headaches
3. Temporomandibular joint (TMJ) syndrome
4. Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI)
5. Fecal incontinence

**M2-05-2272-01**

**Page Four**

6. Raynaud's disease
7. Chronic constipation
8. Irritable bowel syndrome
9. Refractory severe subjective tinnitus.

Biofeedback is typically considered experimental, investigational, or non-efficacious for most other indications, including:

1. Essential hypertension
2. Anterior shoulder instability or pain
3. Attention deficit hyperactivity disorder
4. Anxiety disorders
5. Chronic pain (e.g., fibromyalgia) other than migraine and tension headache
6. Intractable seizures
7. As a rehabilitation modality for spinal cord injury, spasmodic torticollis, or following knee surgeries
8. Spasticity secondary to cerebral palsy
9. Addictions
10. Depression
11. Insomnia
12. Allergy
13. Autism
14. Chronic fatigue syndrome
15. Daytime syndrome of urinary frequency
16. Vertigo/disequilibrium
17. Urinary retention.
18. Post-traumatic stress disorder

1. Milam DF, Franke JJ. Prevention and treatment of incontinence after radical prostatectomy. *Semin Urol Oncol.* 1995;13(3):224-237.

2. Wright EF, Schiffman EL. Treatment alternatives for patients with masticatory myofascial pain. *J Am Dent Assoc.* 1995;126:1030-1039.
3. Bleijenberg G, Kuijpers HC. Biofeedback treatment of constipation: A comparison of two methods. *Am J Gastroenterol.* 1994;89(7):1021-1026.
4. Velio P, Bassotti G. Chronic idiopathic constipation: Pathophysiology and treatment. *J Clin Gastroenterol.* 1996;22(3):190-196.
5. Rao SS, Enck P, Loening-Baucke V. Biofeedback therapy for defecation disorders. *Dig Dis.* 1997;15(Suppl 1):78-92.
6. Barbaresi WJ. Primary-care approach to the diagnosis and management of attention-deficit hyperactivity disorder. *Mayo Clin Proc.* 1996;71:463-471.
7. Watson CG, Tuorila JR, Vickers KS, et al. The efficacies of three relaxation regimens in the treatment of PTSD in Vietnam War veterans. *J Clin Psychol.* 1997;53(8):917-923.
8. Ko CY, Tong J, Lehman RE, et al. Biofeedback is effective therapy for fecal incontinence and constipation. *Arch Surg.* 1997;132(8):829-833; discussion 833-834.
9. Bogaards MC, ter Kuile MM. Treatment of recurrent tension headache: A meta-analytic review. *Clin J Pain.* 1994;10(3):174-190.
10. National Headache Foundation (Tension-type headache, 4/95 ; Migraine, 10/95).
11. Freedman RR, Ianni P, Wenig P. Behavioral treatment of Raynaud's disease: Long-term follow-up. *J Consult Clin Psychol.* 1985;53(1):136.
12. Podoshin L, Ben-David Y, Fradis M, et al. Idiopathic subjective tinnitus treated by biofeedback, acupuncture and drug therapy. *Ear Nose Throat J.* 1991;70(5):284-289.
13. Landis B, Landis E. Is biofeedback effective for chronic tinnitus? An intensive study with seven subjects. *Am J Otolaryngol.* 1992;13(6):349-356.
14. Bigos S, Bowyer O, Braen G, et al. Acute low back problems in adults. Clinical Practice Guideline No. 14, AHCPR Publication No 95-0642. Rockville, MD. Agency for Health Care Policy & Research, Public Health Services, U.S. Department of Health and Human services, December 1994.
15. Vlaeyen JW, Haazen IW, Schuerman JA, et al. Behavior rehabilitation of chronic low back pain: Comparison of an operant treatment, an operant-cognitive treatment and an operant-respondent treatment. *Br J Clin Psychol.* 1995;34(Pt 1):95-118.

16. No authors listed. Integration of behavioral and relaxation approaches into the treatment of chronic pain and insomnia. NIH Technology Assessment Panel on Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia. *JAMA*. 1996;276(4):313-318.
17. Cott A, Pavloski RP, Black AH. Reducing epileptic seizures through operant conditioning of central nervous system activity: Procedural variables. *Science*. 1979;203(4375):73-75.
18. No authors listed. American College of Physicians. Biofeedback for neuromuscular disorders. *Ann Intern Med*. 1985;102:854-858.
19. Schleenbaker RE, Mainous AG. Electromyographic biofeedback for neuromuscular reeducation in the hemiplegic stroke patients: A meta analysis. *Arch Phys Med Rehabil*. 1993;74:1301-1304.
20. McGrady A. Effects of group relaxation training and thermal biofeedback on blood pressure and related physiological and psychological variables in essential hypertension. *Biofeedback and Self Regul*. 1994;19(1):51-66.
21. Alderman MH. Non-pharmacological treatment of hypertension. *Lancet*. 1994;344:307-311.
22. No authors listed. The Fifth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med*. 1993;153:154-183.
23. Weatherall M. Biofeedback or pelvic floor muscle exercises for female genuine stress incontinence: A meta-analysis of trials identified in a systematic review. *BJU Int*. 1999;83(9):1015-1016.
24. Spence JD, Barnett PA, Linden W, et al. Lifestyle modifications to prevent and control hypertension. 7. Recommendations on stress management. Canadian Hypertension Society, Canadian Coalition for High Blood Pressure Prevention and Control, Laboratory Centre for Disease Control at Health Canada, Heart and Stroke Foundation of Canada. *CMAJ*. 1999;160(9 Suppl):S46-S50.
25. McDowell BJ, Engberg S, Sereika S, et al. Effectiveness of behavioral therapy to treat incontinence in homebound older adults. *J Am Geriatr Soc*. 1999;47(3):309-318.
26. No authors listed. Position statement: Coverage for pelvic floor biofeedback therapy. The Continence Coalition of the Society of Urological Nurses and Associates (SUNA) and the Wound, Ostomy and Continence Nurses Society (WOCN). *J Wound Ostomy Continence Nurs*. 1999;26(1):22A-24A.

27. Thompson B, Geller NL, Hunsberger S, et al. Behavioral and pharmacologic interventions: The Raynaud's Treatment Study. *Control Clin Trials*. 1999;20(1):52-63.
28. Visco AG, Figuers C. Nonsurgical management of pelvic floor dysfunction. *Obstet Gynecol Clin North Am*. 1998;25(4):849-865, vii.
29. Wyman JF, Fantl JA, McClish DK, et al. Comparative efficacy of behavioral interventions in the management of female urinary incontinence. Continence Program for Women Research Group. *Am J Obstet Gynecol*. 1998;179(4):999-1007.
30. Lubar JF. Electroencephalographic biofeedback methodology and the management of epilepsy. *Integr Physiol Behav Sci*. 1998;33(2):176-207.
31. No authors listed. Guidelines for the management of chronic headache. From: Recommendations for the therapy of chronic headaches, issued by the Drug Commission of the German Medical Community. *Z Arztl Fortbild Qualitatssich*. 1997;91(8):747-750.
32. Young WB, Silberstein SD, Dayno JM. Migraine treatment. *Semin Neurol*. 1997;17(4):325-333.
33. Riabus MV, Kolosova Oa, Vein AM. The treatment of tension headaches by means of biofeedback. *Zh Nevrol Psikhiatr Im S S Korsakova*. 1997;97(11):67-70.
34. Blanchard EB, Eisele G, Vollmer A, et al. Controlled evaluation of thermal biofeedback in treatment of elevated blood pressure in unmedicated mild hypertension. *Biofeedback Self Regul*. 1996;21(2):167-190.
35. Hunyor SN, Henderson RJ, Lal SK, et al. Placebo-controlled biofeedback blood pressure effect in hypertensive humans. *Hypertension*. 1997;29(6):1225-1331.
36. Leahy A, Clayman C, Mason I, et al. Computerized biofeedback games: A new method for teaching stress management and its use in irritable bowel syndrome. *J R Coll Physicians Lond*. 1998;32(6):552-556.
37. Dalton CB, Drossman DA. Diagnosis and treatment of irritable bowel syndrome. *Am Fam Phys*. 1997;55(3):875-880.
38. Verne GN, Cerda JJ. Irritable bowel syndrome. Streamlining the diagnosis. *Postgrad Med*. 1997;102(3):197-208.
39. Wyler AR, Robbins CA, Dodrill CB. EEG operant conditioning for control of epilepsy. *Epilepsy*. 1979;20(3):279-286.
40. No authors listed. Summary of the practice parameters for the assessment and treatment of children and adolescents with substance abuse disorders. American Academy of Child and Adolescent Psychiatry. *J Acad Child Adolescent Psychiatr*. 1998;37(1):122-126.

41. Schneider F, Heimann H, Mattes R, et al. Self-regulation of slow cortical potentials in psychiatric patients: Depression. *Biofeedback Self Regul.* 1992;17(3):203-214.
42. Waldkoetter R, Sanders G. Auditory brainwave stimulation in treating alcoholic depression. *Percept Mot Skills.* 1997;84(1):226.
43. Morin CM, Hauri PJ, Espie CA, et al. Nonpharmacologic treatment of chronic insomnia. An American Academy of Sleep Medicine review. *Sleep.* 1999;22(8):1134-1156.
44. Bracher ES, Almeida CI, Almeida RR, et al. A combined approach for the treatment of cervical vertigo. *J Manipulative Physiol Ther.* 2000;23(2):96-100.
45. Glazier DB, Ankem MK, Ferlise V, et al. Utility of biofeedback for the daytime syndrome of urinary frequency and urgency of childhood. *Urology.* 2001;57(4):791-793; discussion 793-794.
46. Huntley A, White AR, Ernst E. Relaxation therapies for asthma: A systematic review. *Thorax.* 2002;57(2):127-131.
47. Norton C, Hosker G, Brazzelli M.. Biofeedback and/or sphincter exercises for the treatment of faecal incontinence in adults (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford, UK: Update Software.
48. Brazzelli M, Griffiths P. Behavioural and cognitive interventions with or without other treatments for defaecation disorders in children (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford, UK: Update Software.
49. Stones RW, Mountfield J. Interventions for treating chronic pelvic pain in women (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford, UK: Update Software.
50. Sureshkumar P, Bower W, Craig JC, Knight JF. Treatment of daytime urinary incontinence in children: A systematic review of randomized controlled trials. *J Urol.* 2003;170(1):196-200; discussion 200.
51. *Textbook of traumatic Brain Injury* J.M Silver et. al. American Psychiatric Press, 2005.
52. Van Etten, M.L. & Taylor, S. (1998). Comparative efficacy of treatments for posttraumatic stress disorder: A meta-analysis. *Clinical Psychology & Psychotherapy*, 5, 126-144.
53. Silver, S.M., Brooks, A., & Obenchain, J. (1995). Eye movement desensitization and reprocessing treatment of Vietnam war veterans with PTSD: Comparative effects with biofeedback and relaxation training. *Journal of Traumatic Stress*, 8, 337-342.

54. ACOEM chapter 12 page 300. "Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Insufficient evidence exists to determine effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At home local applications of heat or cold are as effective as those performed by therapists. Furthermore, "American College of Occupational and Environmental Guidelines (ACOEM) chapter 6, page 107, reads: "The immediate focus should be functional improvement rather than on abolishing pain. Physicians should be aware that while complete cessation of pain may not be a realistic goal for some patients, self-care, functional restoration, and successful reintegration into the workforce can be attainable goals even though the complete elimination of pain may not be possible." Furthermore, there are many dimensions to pain. Furthermore, pain related to fear avoidance models typically describe chronic pain patients and perpetuate disability. ACOEM chapter 6 goes on to state, page 113 "Exposing patients to activities they fear as a way to reduce their pain-related fear can be a powerful intervention for chronic pain. A decline in pain related fear may reduce pain vigilance, resulting in a decline in reported pain intensity." The proposed biofeedback would not provide in vivo exposure to feared activities that purportedly generate pain.

This review was conducted on the basis of medical and administrative records provided with the assumption that the material is true and correct.

This decision by the reviewing physician with Professional Associates is deemed to be a Commission decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

**M2-05-2272-01**

**Page Ten**

If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision. A request for a hearing should be faxed to 512-804-4011 or sent to:

Chief Clerk of Proceedings/Appeals Clerk  
TDI-Division of Workers' Compensation  
P. O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization's decision was sent to the respondent, the requestor, DWC, and the claimant via facsimile or U.S. Postal Service this day of 09/26/05 from the office of Professional Associates.

Sincerely,

Lisa Christian  
Secretary/General Counsel