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Notice of Independent Review Decision

DATE OF REVIEW: August 29, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Individual psychotherapy 1 per week x 4 weeks (90806)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The physician providing this review is a Psychologist. The reviewer is licensed in Psychology in the State of Texas. The reviewer is a member of the American Psychological Association, and the International Neuropsychological Society. The reviewer has been in active practice for 30 years.

REVIEW OUTCOME

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

☒ **Upheld** (Agree)

Medical documentation does not support the medical necessity of Individual psychotherapy 1 per week x 4 weeks (90806)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Utilization reviews (07/15/08 – 08/04/08)

- X-rays (05/28/08)
- Office notes (06/13/08 – 07/02/08)
- Utilization reviews (07/15/08 – 08/04/08)

- X-rays (05/28/08)
- Office note (07/02/08 – 08/04/08)
- Utilization reviews (07/15/08 – 08/04/08)

ODG has been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old male who was injured on xx/xx/xx while lifting 25-30 lb. boxes repetitively and felt pain in his neck and upper back.

Initially, the patient came under the care of , D.C., who ordered x-rays. X-rays of the cervical spine revealed straightening of the lordotic curve. X-rays of the thoracic spine were normal except for misaligned T1 and T2 vertebrae on the right posteriorly. X-rays of the lumbar spine revealed mild increase in the lordotic curve. Dr. recommended individual counseling as the patient was anxious and depressed due to pain from the injury.

, M.A., L.P.C., noted the following: *The patient had injury to his cervical and lumbar spine in 2007. He completed a work hardening program (WHP) and had returned to work successfully. The patient was terminated after the current injury.* The patient reported his pain at 3/10 with intermittent elevation to 6/10. He was utilizing Advil/Aleve. The pain interfered with his recreational, social, and familial activities; normal activities; and ability to work due to pain. The patient scored 2 on the Beck Depression Inventory-II (BDI-II) and 3 on Beck Anxiety Inventory (BAI), which indicated minimal depression and anxiety. Ms. stated that the scores appeared minimized and might be influenced by educational experience, reading comprehension, or examinee bias. She diagnosed unspecified adjustment disorder related to the work injury and recommended four sessions of individual psychotherapy. She stated that the patient would be an excellent candidate for an intensive pain control intervention if for some reason he did not derive benefit from individual psychotherapy.

On July 15, 2008, , Ph.D., denied the request for four sessions of individual psychotherapy with the following rationale: *"In support of this request, psychological self-report instruments were administered. Negligible evidence of anxiety or depression was documented. The bio-behavioral intervention requested appears not to be medically necessary at this time. References used in support of Decision: ODG congnitive behavioral therapy (CBT) guidelines: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical therapy exercise instruction, using a cognitive motivational approach to PT. Consider separate psychotherapy CBT referral after four weeks if lack of progress from PT alone: Initial trial of 3-4 psychotherapy visits over two weeks, with evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)."*

Ms. responded to this as: *"The patient was referred to our office on June 13, 2008 for individual counseling. He has completed physical therapy as of July 14 and we are requesting for a brief stint of individual therapy to address his coping and self-management of pain symptoms. Further, addressing his beliefs about his functional abilities in the world of work is clearly indicated. He is pending his EMG/NCV to be scheduled. He still presents as having mood disturbance across office visits. Based on the clinical information, it has been determined that a brief stint of individual psychotherapy would stabilize the patient's active mood disturbance and enhance his ability to benefit from prescribed treatment by improving his coping skills to manage injury-related psychological stressors."*

On August 4, 2008, Ph.D., denied the request for reconsideration of individual psychotherapy sessions with the following rationale: *"This patient has minimal*

psychological factors. He was also just injured within the last three months. Moreover, his pain complaints appear minimal and he is utilizing OTC medications only. Based on the documentation provided, objective and subjective findings, this request is not medically necessary."

On August 4, 2008, , Ph.D., stated as: *"Peer reviewed request for 4 individual psychotherapy (IPT) sessions of the patient with Dr. . I summarized the patient's work injury, the employer's termination the day after the injury – though he had worked for this company for six years at the time of the work injury, and denial of his entire claim and difficulty getting needed medical treatment. Dr. noted that the patient reported very low scores on the Beck and PSRS. It was explained that the patient attempted to minimize his distress."*

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

THE CLAIMANT WAS PSYCHOLOGICALLY EVALUATED ON 7/20/08 BY MS. . SHE DESCRIBED HIS MOOD AS "EUTHYMIC" AND HIS AFFECT AS "BROAD". HE SUBJECTIVELY RATES HIS ANXIETY/WORRY AS 1/10 AND HIS DEPRESSION AS 1/10. OBJECTIVE PSYCHOLOGICAL TESTING FOUND HIS LEVEL OF DEPRESSION TO BE IN THE NORMAL RANGE (BDI-II=2) AND HIS LEVEL OF ANXIETY TO BE IN THE NORMAL RANGE (BAI=3). THERE ARE NO DESCRIPTIONS EITHER OF BEHAVIOR OR OF SUBJECTIVE COMPLAINTS INDICATIVE OF EITHER DEPRESSION OR ANXIETY. NO TESTING WAS INDICATIVE OF EITHER DEPRESSION OR ANXIETY. THERE IS NO APPARENT BASIS FOR MS. RAMERIZ TO REACH THE DIAGNOSIS OF ADJUSTMENT DISORDER, UNSPECIFIED. THE ODG RECOMMENDS INIDIVIDUAL PSYCHOTHERAPY FOR THE TREATMENT OF ANXIETY AND DEPRESSION: ODG Psychotherapy Guidelines: 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). (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)

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).

However there is no evidence that the claimant suffers either depression or anxiety. Ms. Rameriz opines that the claimant is minimizing his level of depression, yet offers no description of the behaviors that lead her to that opinion. On the contrary, he consistently reports minimal symptoms of both. There is no basis for the opinion that he is distressed and thus there is no medical necessity for psychotherapy.

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

ODG- ONLINE WEB EDITION