



IMED, INC.

1701 N. Greenville Ave. • Suite 202 • Richardson, Texas 75081
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 08/04/08

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Six sessions of individual psychotherapy

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

Texas Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 06/28/07 –Behavioral.
2. 02/25/08 –Inc.
3. 02/25/08 – D.C.
4. 03/05/08 – Comprehensive pain management evaluation treatment request.
5. 03/10/08 –D.C.
6. 04/09/08 – Initial diagnostic screening.
7. 04/28/08 –Health Associates.
8. 05/01/08 –
9. 06/02/08 –D.C.
10. 06/26/08 –Behavioral.
11. 06/27/08 –
12. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury to the low back on xx/xx/xx while unloading 3 rolls of carpet. He reports the load was approximately 1000 lbs. Treatment

to date has included medications management, active and passive PT, epidural injections and 5 surgeries. In 4/08 the employee was seen for a psychological evaluation. Medications at that time included Hydrocodone, Gabapentin, Aspirin, Paroxetine, Alprazolam, Prevacid and Advicor. His complaints at the time of the evaluation included pain, very limited function, severe depression, significant disability, anxiety, and poor concentration, fear of re injury, sleep disruption and financial strain. Beck depression and anxiety inventories were performed; scores were 12 and 31 respectively. Pain experience scales revealed a moderate level of emotional and worry response. Owestry revealed a score placing the employee in the "crippling disability" range. Diagnostic impression was generalized anxiety disorder. Recommendation was made for participation in 6 sessions of IPT. On 5/1/08 the request was denied due to minimal objective psychological factors. It was also noted the injury was over xx years old and the employee had not attempted to return to work. In response, a letter of reconsideration was submitted indicating there was evidence per employee complaint of mild to moderate depression and severe anxiety. The OD Guidelines were also provided as support for the request. On 7/2/08 the appeal request for IPT was reviewed and upheld. The reviewer indicated there was no objective evidence to support why his psychological symptoms are causing delayed recovery and no indication symptoms magnification had been ruled out. It was also noted there were several deficiencies in the initial review and in reconsideration these deficiencies were not addressed. A request was then submitted for independent review.

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

I would have to concur with the initial and the appeal determinations. This is an injury that is over xx years old. The psychological evaluation provided significant subjective evidence of depression and anxiety but nothing objective to quantify it. This employee however had never attempted return to work and this is indicative of a poor predictor for outcome of success. While ODG does in fact recommend cognitive therapy for employees with depression, pain disorders, and adjustment disorder, there was not sufficient objective documentation to support the psychological diagnosis. As such based on the documentation provided, the denial is upheld.

From ODG

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 outemployees 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 employees did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological
----------------------------------	--

	<p>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 employees 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)</p> <p>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)</p>
--	--

Psychological testing. This supplements information provided in the clinical interview and, at the minimum, should evaluate personality style and coping ability. At least one test should contain validity scales. The current “gold standard” is the Minnesota Multiphasic Personality Inventory (MMPI, or a second version, the MMPI-2). MMPI scores of concern are findings of elevated neurotic triad scores (scales 1,2, and 3; also defined as hypochondriasis [Hs], depression [D], and hysteria [Hy], or a Conversion V score [elevations of scales 1 and 3 at least 10 points above scale 2]). See [Minnesota multiphasic personality inventory](#) (MMPI). Other tests have included the Spielberger State-Trait Anxiety Inventory (STAI), Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Hospital Anxiety and Depression Scale (HAD), Millon Clinical Multiaxial Inventory (M-CMI-II), Symptom Checklist-90-R (SCL-90-R), Behavioral Analysis of Pain, Chronic Illness Problem Inventory (CIPI), McGill Pain Questionnaire (MPQ), Coping Strategies questionnaire (CSQ), and Pain Beliefs and Perception Inventory (PBPI).

<p>Minnesota multiphasic personality inventory (MMPI)</p>	<p>Recommended to determine the existence of suspected psychological problems that are comorbid with chronic pain, to help to tailor treatment. Not recommended as an initial screening tool for all cases of chronic pain. The MMPI and a revised version, MMPI-2, provide a psychological questionnaire that contains three validity scales and ten clinical scales that assesses the employee’s levels of somatic concern, depression, anxiety, paranoid and deviant thinking, antisocial attitudes, and social introversion-extraversion. The instrument, one of the most commonly used assessment tools in chronic pain clinics, can be useful to evaluate which behaviors and expressions related to pain are secondary to psychological stress and which are related to personality traits. The tool has not been shown to be useful as a screening tool for multidisciplinary pain treatment or for surgery. It is not recommended as an initial screening tool for general psychological adjustment in relationship to chronic pain. It cannot be used to corroborate the differential between organic and functional-based pain. Several MMPI profiles have been described in relation to pain employees:</p> <ul style="list-style-type: none"> - Conversion V profile: An elevation of scores on the
---	---

	<p>hypochondriasis scale (scale 1, Hs) and hysteria scale (scale 3, Hy), with at least 10 points greater on these scales than on the depression scale (scale 2, D). Evidence of this profile has been interpreted as evidence of a preexisting personality that is a major contributing factor in chronic low back pain, although this is disputed. Elevations of hypochondriasis (scale 1) and hysteria (scale 3) have been found to negatively correlate with return to work.</p> <p>- “Neurotic triad”: has been coined to describe a cluster of elevated scores of hypochondriasis, depression and hysteria. Evidence has been supportive that these scales are consistently elevated in pain employees, predicting both decreased short- and long-term pain relief. Evidence has also been found to be conflicting as to whether scales 1 and 3 are associated with functional impairment related to pain.</p> <p>- PAIN: A clustering of pain scales based on the MMPI that was described by Costello, et al., including the following: P: Nearly all scales are elevated; A: The Conversion V profile; I: The “neurotic triad”; & N: Normal.</p> <p>Criteria for Use of the MMPI:</p> <p>(a) To determine the existence of psychological problems that are comorbid with chronic pain;</p> <p>(b) To help to pinpoint precise psychological maladjustment and help to tailor treatment;</p> <p>(c) To garner information that may help to develop rapport and enhance level of motivation;</p> <p>(d) To detect psychological problems not discussed in the clinical interview. One particular area that may be helpful is the use of the Addiction Acknowledgement Scale.</p>
--	---

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

1. **Official Disability Guidelines**, Return To Work Guidelines (2007 Official Disability Guidelines, 12th edition) Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 5th edition) Mental Illness Chapter, Accessed Online