



## Notice of Independent Review Decision

### **DATE OF REVIEW:**

12/04/2008

### **IRO CASE #:**

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

Cognitive behavioral treatment for depression and anxiety (ten additional sessions of individual psychotherapy every two weeks).

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

Board Certified Clinical Psychologist

### **REVIEW OUTCOME**

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**The requested ten (10) additional sessions of individual psychotherapy (CPT 90806) is not medically necessary.**

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 11/21/08 MCMC Referral
- 11/20/08 to 11/24/08, 11/10/08, 11/09/08, 11/06/08, 11/03/08, 10/29/08, 10/20/08, 10/08/08, 09/29/08, 09/15/08, 08/25/08, 08/04/08, 07/21/08, 06/23/08, 06/09/08, 06/02/08, 05/20/08, 05/05/08, 04/23/08, 04/07/08, 03/24/08, 03/10/08, 02/25/08, 02/11/08, 02/04/08, 01/28/08 office notes, PhD
- 11/20/08 Notice To Utilization Review Agent Of Assignment
- 11/20/08 Notice To MCMC, LLC Of Case Assignment
- 11/20/08 letter from attorneys
- 11/20/08 Confirmation Of Receipt Of A Request For A Review, DWC
- 11/19/08 Request For A Review By An Independent Review Organization
- 11/10/08 Reconsideration/Appeal of Adverse Determination letter, Utilization Review Department
- 10/29/08 Utilization Review Determination letter, Utilization Review Department
- 10/29/08 letter from Ph.D.
- 10/23/08 Treatment Authorization Request, Ph.D.
- 07/24/08 Treatment Authorization Request, Ph.D.
- 04/20/08 Treatment Authorization Request, Ph.D.

- 04/07/08, 01/28/08 Request/Authorization to Release/Obtain Confidential Records and Information, Ph.D.
- 01/28/08 authorization form for treatment and/or diagnosis procedures, Ph.D.
- 01/28/08 signed authorization of receipt of Policies and Practices, Ph.D.
- 01/28/08 Consent to Treatment, Ph.D.
- 01/28/08 handwritten patient evaluation, Ph.D.
- Note: Carrier did not supply ODG Guidelines.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured individual's date of injury is listed as xx/xx/xx. The mechanism of this injury was not submitted in reviewed documentation, nor was a rationale for providing therapy over xx/xx after this injury. He apparently has been seeing a psychologist and psychiatrist. The basis for this care was not established in submitted documentation. The psychologist reportedly has completed eighteen previous psychotherapy sessions. If "functional improvement" can be established – thirteen to twenty sessions of such therapy may be approved. In this case, the submitting psychologist did not provide or submit evidence explaining why her proposed care should exceed published guidelines. The basis for providing psychological intervention over eleven years after his injury was not explained in submitted documentation. Based on a review of the submitted documentation, the requested additional psychotherapy is not medically necessary.

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

The injured individual is seeing a psychologist and a psychiatrist. The basis for this care was not established in submitted documentation. Based on documentation, he has completed eighteen previous psychotherapy sessions with the psychologist. The psychologist is requesting ten additional sessions. The basis for extending additional psychotherapeutic care to this individual was not established. The additional care requested exceeds Official Disability Guidelines (ODG).

**CRITERIA:** ODG: Psychological treatment is 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:

Step 1: 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.

Step 2: 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.

Step 3: 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 [Multi-disciplinary pain programs](#). See also [ODG Cognitive Behavioral Therapy \(CBT\) Guidelines](#). ([Otis, 2006](#)) ([Townsend, 2006](#)) ([Kerns, 2005](#)) ([Flor, 1992](#)) ([Morley, 1999](#)) ([Ostelo, 2005](#))

Also see:

Psychological treatment is recommended. 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 or physical dependence. See the [Low Back Chapter](#), “Behavioral treatment”, and the [Stress/Mental Chapter](#). See also [Multi-disciplinary pain programs](#).

ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:

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](#) for [exercise](#) 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 [functional improvement](#), 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 [Mental/Stress Chapter](#), repeated below.

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)

Extremely severe cases of combined depression and PTSD may require more sessions if documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials. Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders. ([Leichsenring, 2008](#))

The medical necessity of the requested care was not established. Submitted documentation provided no basis for exceeding published guidelines. The requesting psychologist did not submit any additional documentation outlining her reasons for the requested care.

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

### **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

### **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

- *Handbook of Pain Syndromes*. Mahwah, NJ: Lawrence Erlbaum Publishers, 1999-pages 77-97.

- American College of Occupational and Environmental Medicine. *Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers*. Massachusetts: OEM Press, 2<sup>nd</sup> Edition, 2003.
- Nielson, W.R. & Weir, R. (2001). "Biopsychosocial approaches to the treatment of chronic pain." *Clinical Journal of Pain*, 17(4 Suppl), S114-S127.
- Roberts, A. H., R. A. Sternbach, et al. (1993). "Behavioral management of chronic pain and excess disability: long-term follow-up of an outpatient program." *Clin J Pain* 9(1): 41-8.
- Flor, H., D. J. Behle, et al. (1993). "Assessment of pain-related cognitions in chronic pain patients." *Behav Res Ther* 31(1): 63-73.
- Maloney, K et al. An overview of outcomes research and measurement. *J Health Care Quarterly*, 1999; Nov-Dec; 21(6):4-9.
- Lambert MJ, editor. Bergin and Garfield's handbook of psychotherapy and behavior change. 5<sup>th</sup> ed. John Wiley and Sons, New York. 2004.
- Gatchel, Robert J., *Clinical Essentials of Pain Management*, 2005, American Psychological Association.
- Turk, D.C. & Gatchel, R.J. (Eds.). *Psychological Approaches to Pain Management: A Practitioner's Handbook*, Second Edition. New York: Guilford Press, 2002.