

Applied Resolutions LLC

An Independent Review Organization
1124 N. Fielder Road, #179, Arlington, TX 76012
(512) 772-1863 (phone)
(512) 853-4329 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 07/14/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Psychotherapy, 6 sessions over 12 weeks

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

Clinical Psychologist, Member American Academy of Pain Management

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)

Upon independent review the reviewer finds that the requested Individual Psychotherapy, 6 sessions over 12 weeks is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 5/15/08, 6/11/08
ODG Guidelines and Treatment Guidelines
LPC Progress Reports for 8/28/06 to 9/14/06, 7/3/06 to 8/7/06, 5/4/06 to 6/1/06, 10/4/06 to 10/31/06, 6/9/07 to 8/9/07 and 12/27/07
Goals and Objectives 11/8/06
Appeal Letter 5/12/08
Medication Sheet
Patient Intake Form
Consult/ History and Physical 7/20/07

MRI's Right Shoulder, Left Shoulder and Lumbar Spine 7/24/07
Carrier's Coverletter with Position Statement
ODG Treatment Guidelines, Shoulder
PLN-11 10/6/05
DO 2/9/07
MD 9/19/05
DO 1/6/04, 1/7/04, 1/9/04, 1/12/04, 1/15/04, 1/19/04, 1/20/04, 2/2/04, 2/13/04
MD 1/16/04, 2/17/05
MD 2/26/04 to 8/23/05
Hospital 5/19/04
Surgery Center 7/26/04
MD 3/7/05
MD 4/28/05
MD 6/13/05
MD 9/2/05, 9/29/05, 11/1/05, 11/29/05
LPC, 9/2/05, 2/3/06, 3/3/06
DC/, MS, LPC 3/16/06 to 1/8/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old male who was injured on xx/xx/xx while performing his regular job duties. History of injury is sparse, but records indicate patient has received the following diagnostics and interventions to include: initial and follow-up medical evaluations, medications management to include Naprosyn, Norco, and Elavil, x-rays, shoulder MRI's, lumbar MRI's, right shoulder arthrogram (2-17-05), FCE, physical therapy, shoulder surgeries, individual counseling, and 31 days of a chronic pain management program. Records indicate patient was referred for a surgical consult in August of last year, and that this is still pending. Patient is currently not working. He is currently diagnosed with Adjustment disorder, unspecified and pain in the shoulder joint.

From 05-06 to 06-06, patient received 4 IT sessions, then this was followed by a 31 day CPMP from 7/06-8/06. During this time, BDI scores decreased from 14 to 11 and BAI scores decreased from 3 to 2. Medications were decreased by 50%. More recently 6 additional IT sessions have been completed, with BDI reductions from 16 to 12, and BAI reductions from 14 to 2. Current request is for 6 additional sessions, every other week. Goals for IT are to decrease BDI score by 6 points (from a 12 to a 6), decrease Oswestry by 10 points, and decrease sleep questionnaire by 10 points.

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

ODG recommends cognitive-behavioral therapy for depression, stating that "the gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy." However, in this case, patient's depression has historically been at the borderline to mild ranges, and therefore probably does not necessitate intervention with psychotropic medications.

Additionally, patient appears to be pending a surgical consult, and possible additional surgery. It is therefore premature to undertake more individual therapy to deal with an adjustment disorder, when underlying possible pain generators have not been addressed.

In addition, the ODG TWC stress chapter states that initial evaluation should "focus on identifying possible red flags or warning signs for potentially serious psychopathology

that would require immediate specialty referral. Red flags may include impairment of mental functions, overwhelming symptoms, signs of substance abuse, or debilitating depression. In the absence of red flags, the occupational or primary care physician can handle most common stress-related conditions safely". Therefore, I find that the requested 6 sessions of Individual Psychotherapy over 12 weeks is not medically necessary at this time.

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 outpatients 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 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)

ODG cognitive behavioral therapy (CBT) guidelines for low back problems:

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs.

Initial therapy for the "at risk" patients should be physical therapy 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)

Psychological treatment: 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 comorbid 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 for low back problems. ([Otis, 2006](#)) ([Townsend, 2006](#)) ([Kerns, 2005](#)) ([Flor, 1992](#)) ([Morley, 1999](#)) ([Ostelo, 2005](#))

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)