

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision- **Amended**

DATE OF REVIEW: 6/17/2008 AMENDED 6/25/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

6 sessions of Individual Psychotherapy

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 6 sessions of Individual Psychotherapy is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 4/16/08, 5/7/08

ODG Guidelines and Treatment Guidelines

Spine & Rehab, 2/26/08, 12/26/07, 12/21/07, 12/19/07, 12/17/07, 12/14/07, 12/13/07, 12/5/07, 11/28/07, 11/21/07, 11/19/07, 5/23/08, 4/25/08, 3/14/08

MRI, Left Ankle, 2/14/08

Lumbar Spine Series, 11/30/07

Cervical Spine Series, 2/14/08

MRI Lumbar Spine, 12/14/07

Electrodiagnostic Study, 3/3/08

Dr. DC, 3/3/08
Medical Consultants Network, 3/6/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx performing his regular job duties as a . He states he was in the process of carrying a large sheet pan, when he tripped over a missing floor tile and fell in a twisting backward motion, injuring his left ankle and low back. He felt onset of pain in his ankle and low back, and went to Clinic the following day, where he received x-rays, ibuprofen, and ankle brace, and was released to light duty. Patient is currently not working, and still experiencing pain at an average of 8/10 VAS.

Over the course of his therapy and treatments, patient has received diagnostics and interventions to include: passive, and some active, chiropractic rehabilitation, MRI's, EMG, and medications management, with little overall improvement. MRI of the lumbar spine done 12/14/07 showed broad-based right lateral disc protrusion at L3-4. There is also a mild posterior disc protrusion at L5-S1 and L4-L5. MRI of the left ankle done on 2/14/08 showed longitudinal splitting tear of the peroneus brevis tendon, tendinosis and intrasubstance tearing of the distal posterior tibial tendon. Medications include Vicodin, Tramadol, and Soma.

On 3-06-08, RME was conducted that stated that "claimant needs to be referred to a pain management specialist for further evaluation and to receive a series of epidural steroid injections. He also needs an orthopedic evaluation of his left ankle."

On 3-14-08, a behavioral health evaluation was conducted by, LPC, per referral from the treating physician. At this evaluation, the claimant rated his pain level at 8/10 and his average daily pain level at 8/10, with intermittent decreases to 3/10. Report indicates patient "has been unable to find resolution for his pain and has found it difficult to cope and manage his condition and its limitations". He was given diagnoses of: adjustment disorder with mixed anxiety and depressed mood, pain disorder, chronic pain syndrome, lumbar, cervical and ankle strain/sprain. Goals for IT were to decrease BDI score by 30%, decrease pain by 10 to 20%, improve sleep from 4-6 hours up to 7-8 hours, begin psychotropic medication, education regarding negative thinking patterns, vocational rehabilitation, improved motivation and energy levels, and improved GAF by 10-15 points. Current request is for individual psychotherapy 1x6.

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

ODG has been adopted by TDI as the evidence-based standard on which all requests for services are evaluated. 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 has not been evaluated for, or prescribed, a trial of psychotropic medications, and there is no pending referral in the records available for review.

Additionally, the RME referrals for orthopedic evaluation and ESI’s are also not apparent. It is therefore premature to undertake individual therapy to deal with a chronic pain syndrome, when underlying possible pain generators have not been addressed. In the reconsideration for IT report, it is opined that patient “is experiencing depression due to not being able to work and not being able to do the activities that he used to do before he was injured. He needs therapeutic support for him to be able to change his view of his situation”. It is premature to assume this posture at this time, given that the underlying possible pain generators have not been addressed in this patient. Therefore, the request for 6 sessions of Individual Psychotherapy 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 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](#) 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 KNOWLEDGBASE
- AHCP- 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)**