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Notice of Independent Review Decision

DATE OF REVIEW: October 9, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy x6 sessions

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

International Neuropsychological Society
American Psychological Association

REVIEW OUTCOME

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

Overturned (Disagree)

Medical documentation supports the medical necessity of Individual psychotherapy x6 sessions

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Utilization reviews (09/04/08 – 09/17/08)
- Office notes (05/28/08 – 08/20/08)
- Therapy (07/14/08)
- Reviews (07/14/03 & 04/05/05)
- Utilization reviews (09/04/08 – 09/17/08)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx-year-old male who reported an injury on xx/xx/xx, while working as a for . He was picking up some boxes and injured his back as well as hands due to repetitive work.

2003 – 2005: In July 2003, , D.C., performed a medical evaluation (ME) and noted the following: “*The patient initially presented to where he underwent x-*

rays, received medications, and was returned to light duty work. He also went through exercise and rehabilitation and was doing much better. Magnetic resonance imaging (MRI) of the left shoulder showed subacromial bursitis and partial rotator cuff tear. X-rays of the lumbar spine revealed mild osteophytic spurs bilaterally on the superior endplate of L3, which was a nontraumatic finding. The patient was being treated with adjustments and massage and medications including "Centex and Oton". The patient was experiencing symptoms in his low back and legs as well as elbows, hands, and shoulders. He also reported numbness and tingling in the hands. Dr. opined that the patient be returned to modified work for two to three weeks so he could work on his endurance and then return back to full-time duty. He also assessed the patient had reached MMI and no further treatment was needed.

In January 2005, , M.D., a designated doctor, noted the following: "*The patient underwent hemilaminotomy at L3-L4, L4-L5, and L5-S1 with root decompression on May 11, 2004. Since surgery, the patient had improved, but he still had pain in the low back. MRI of the left shoulder revealed tendinosis of the supraspinatus and infraspinatus tendon and unchanged acromioclavicular (AC) joint hypertrophic degenerative changes with impingement on the rotator cuff. MRI of the right shoulder revealed degenerative changes of the AC joint with impingement of the right rotator cuff.*" Dr assessed maximum medical improvement (MMI) and assigned 14% whole person impairment (WPI) rating.

On April 5, 2005, Dr. performed a medical evaluation and noted the patient had undergone left shoulder surgery on xx/xx/xx. The patient was seeing , D.C., two times a week for electrical muscle stimulation (EMS) and heat packs. Dr. opined: The patient was at MMI, the medical documentation did not support a solid causal relationship between the accident and the injury, there was no reasonable or medical rationale for ongoing chiropractic care, and the patient should have been released from light duty and returned to work without restrictions.

2008: The patient came under the care of , M.D., who treated him with oral medications, supraspinatus injections x3, and home exercises.

In an FCE performed on July 14, 2008, the patient qualified for a light-to-medium job physical demand level (PDL). He continued to exhibit decreased range of motion (ROM) and flexibility of the lumbar spine and lower extremities with associated pain; decreased grip strength with the right being weaker; pain upon palpation and while performing the required tasks of the wrists, shoulders, lumbar paraspinal musculature, and lower extremities; and decrease in lifting capacity and work demand tolerance. The patient was aerobically deconditioned. He was recommended participation in vocational rehabilitation to establish vocational goal consistent with his present abilities.

On August 20, 2008, Dr. reported the patient had picked up an object from a floor and could not straighten himself. The patient had relief of his shoulder pain since the injections. Dr. prescribed oral medications.

On August 25, 2008 , Ph.D., performed a psychological evaluation. Beck Depression Inventory (BDI) II score was 25, while Beck Anxiety Inventory (BAI) score was 27. He assessed pain disorder associated with both psychological

factors and general medical condition, adjustment disorder with mixed anxiety and depressed mood, and sleep disorder due to general medical condition. He recommended six sessions of individual psychotherapy to focus on teaching coping strategies.

On September 4, 2008, the request for individual psychotherapy x6 sessions was denied with the following rationale: *“The clinical indication and necessity of this procedure could not be established. The evaluation of August 25, 2008, finds impression of pain disorder, adjustment disorder, and sleep disorder and a chronic pain condition is inferred. Since the psychological and behavioral symptoms are consistent with the inferred diagnosis of pain disorder/chronic pain syndrome, it is unclear what justifies the diagnosis of sleep disorder and adjustment disorder. The limiting problem appears to be complaints of shoulder pain, but there is no behavior analysis to suggest how this affects the patient’s functioning and psychological status (generic subjective ratings are not meaningful in this regard, and FCEs do not control for psychological factors, which should have been addressed in the behavior evaluation). The patient was given some limited psychometric test (BDI, BAI), apparently used for inferences here. However, they are not helpful in the context of chronic pain; and it is not clear that the patient has an adequate reading level to provide valid response to these instruments. The stated goals of this treatment do not appear to be objective and individualized. In sum, because of the above and since the operative factors responsible for continued pain complaint, behavior, and disability are not explicated, there is no evidence that this is an “appropriately identified patient” for this therapy, which is rarely effective in this type of case.”* The carrier disputes that the compensable injury extends to or includes psychological overlay, depression, anxiety, mood disorder, and sleep disturbance.

In a reconsideration request letter dated September 10, 2008, , D.C., explained the following: Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. The cognitive behavior therapy fared as well as antidepressant medications with severely depressed outpatients in four major comparisons. A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment.

On September 17, 2008, the request for reconsideration was denied with the following rationale: *“The letter of Dr. does not address the rationale cited for the initial denial. In addition, the request is based on initial interview dated August 25, 2008, performed by an LPC and based on self-reporting and self-assessment questionnaire (BDI-2 score of 25; BAI score of 27). It should be noted that the evaluator, an LPC, is not trained or credentialed to be able to provide an accurate differential diagnosis and V-axis diagnosis. There are multiple medical conditions (axis III) that can appear to be depressive disorder, multiple personality issues (axis II) that can appear to be depressive disorder, and multiple forensic issues that can appear to be a depressive disorder. Therefore, simply having multiple symptoms and elevated Beck DEPRESSION INVENTORY (BDI) does not lead to a diagnosis of depression. There is no documentation that the employee has undergone any higher level of evaluation, i.e., psychiatric diagnostic interview with an objectively scored psychological and*

neuropsychological testing with physical examination that he has been diagnosed with and treated for depression and/or anxiety by licensed medical provider. LPC's provide a supportive role in the treatment of psycho-behavioral illnesses and there are no clinical records provided from the treating doctor to indicate that the employee has undergone any further evaluations. In addition, there does not appear to be any history of significant psycho-behavioral issues identified in the records prior to the assessment of August 25, 2008. The employee has not worked since the date of injury and the employee has not undergone any additional testing."

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

THE CLAIMANT HAS HAD EXTENSIVE TREATMENT FOR HIS INJURY AND CONTINUES TO BE DISABLED BY PAIN. A PSYCHOLOGICAL EVALUATION FOR THE PURPOSE OF ASSESSING SUITABILITY FOR A CHRONIC PAIN MANAGEMENT PROGRAM DIAGNOSED THE PAIN DISORDER AND ADJUSTMENT DISORDER. PRIOR TO INITIATING A CHRONIC PAIN MANAGEMENT PROGRAM, THE ODG RECOMMENDS A TRIAL OF LOWER LEVEL BEHAVIORAL CARE. THE REQUEST FOR 6 SESSIONS OF INDIVIDUAL PSYCHOTHERAPY MEETS THE ODG RECOMMENDATIONS FOR THE TREATMENT OF DEPRESSION AND ANXIETY.

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).

THE REQUEST APPEARS TO MEET ODG RECOMMENDATIONS AND THUS THE DENIAL OF SERVICES SHOULD BE OVERTURNED.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES