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Notice of Independent Review Decision

DATE OF REVIEW: 09/03/2008

IRO CASE #:

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

This case was reviewed by a Psyciatry, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1 x 6 weeks

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- October 8, 2007 Lumbar MRI report read by Dr.
- December 31, 2007 History and Physical report from Dr.
- January 4, 2008 Request for LESI at L4-5 from Dr.
- January 25, 2008 Lumbar translaminar ESI at L4-5 procedure report from Dr.
- February 1, 2008 Request for LESI at L4-5 from Dr.
- October 8, 2007 Lumbar MRI report as read by Dr.
- March 14, 2008 Follow-up visit report from Dr.
- March 18, 2008 Request for right lumbar facet injections at L4-S1 from Dr.
- April 10, 2008 Lumbar orthopedic/neurologic testing sheet from Dr.
- April 25, 2008 Request for 2 additional post injection PT visits from Dr.
- June 23, 2008 Letter of Medical Necessity for Discogram from Dr.
- July 3, 2008 Initial Behavioral Medicine consultation with 2 Addendums from Dr.
- July 21, 2008 Non-certification for psychotherapy 1 x 6
- July 31, 2008 Request for reconsideration, Behavioral health individual psychotherapy
- August 6, 2008 Non-certification, request for reconsideration, psychotherapy 1 x 6
- August 13, 2008 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records available for my review, the patient is xx-year-old employee who sustained an industrial injury to the lumbar spine on when twisting towards the right to put a steel beam on a rack.

Lumbar MRI of October 8, 2007 shows multilevel central disc protrusions at L3-4 through L5-S1 with significant multi-level bilateral recess stenosis and contact with the S1 nerve roots bilaterally.

The patient was provided a pain management consultation on December 31, 2007. The patient's medical history is positive for hypertension. He reports a constant burning, aching, stabbing pain centered in the right lower back that radiates to his buttocks

and right thigh with intermittent spasm up to the neck. His pain is positional and relieved with rest. His treatment to date has included chiropractic manipulation, physical therapy and TENS with little success. The patient underwent LESI. Medications include Norco, tramadol and Celebrex. He is working 4 hours daily of light duty. The patient is 6 feet tall and 237 pounds with elevated blood pressure of 190/106. On examination, he is tender to palpation over the right L4-5 and L5-S1 facet regions. His pain is exacerbated by flexion greater than 40 degrees and extension greater than 5 degrees. There is diminished sensation in the right L4 through S1 distribution and significant weakness in the right quadriceps of 4/5. Recommendations are for LESI at L4-5. He may be a candidate for diagnostic facet injection. Reduce tramadol/initiate Lyrica.

A translaminar epidural steroid injection was administered on January 25, 2008 which was reported on February 1, 2008 to have provided relief of 60% for a duration of 3 days. On this basis a repeat LESI was requested and subsequently administered on February 29, 2008 which was reported on March 14, 2008 to have provided no significant relief. On March 14, 2008 right-sided facet injections at L4-5 and L5-S1 were discussed and requested on March 18, 2008.

A Letter of Medical Necessity of April 25, 2008 states the patient received his first lumbar ESI (sic) and continues with low back pain and numbness radiating down the right leg. Two additional sessions of post-injection PT were requested.

On June 23, 2008 the provider indicates that the patient has seen a neurosurgeon who recommended lumbar flexion/extension x-rays to clarify any instability and a discogram in consideration of a surgical intervention. A lumbar ESI of April 11, 2008 was reported to have limited benefit. Additionally, on November 11, 2007 the patient underwent a psychological assessment and was found not to have a chronic pain disorder associated with his injury. Review of the assessment indicates the patient has a score indicating moderate depression and moderate anxiety.

A behavioral health consultation was provided on July 3, 2008 to determine if some level of behavioral health intervention was appropriate for the patient. The patient is using medications of Methocarbanol, Celebrex, Lyrica, and Hydrocodone. The patient reports an average pain intensity of 7/10. He estimates his current level of functioning as zero. He reports sleep difficulties and financial distress. He receives support from his church pastor and family. His attention and concentration are normal. His mood appears dysthymic and his affect somewhat constricted. He endorses symptoms indicative of depressive disorder/depression to include: depressed mood, anhedonia, change in appetite, insomnia, fatigue or loss of energy, and diminished ability to concentrate. His diagnosis includes Major Depressive disorder, single episode, moderate, secondary to the work injury. Secondary problems include maladjustment and disturbances in sleep and mood. He will benefit from a brief course of individual psychotherapeutic intervention using CBT approaches.

Request for a brief course of individual psychotherapy was not certified in review on July 21, 2008 following a peer-to-peer discussion with the provider with rationale that a behavioral medicine consultation by someone lacking medical training is not consistent with current disability management standards.

The provider requested reconsideration on July 31, 2008 noting that the patient has an actual physical injury and is not claiming a work-related mental illness. The patient is working a 20 hour week on modified duty and would benefit from learning pacing techniques and relaxation techniques to help tolerate his pain on the job. He is also pending a discogram to see if he is a surgical candidate.

Request for reconsideration for individual psychotherapy times six visits was not certified in review on August 7, 2008 following a peer-to-peer discussion with the provider with rationale that the claimant is working a 20 hour week and being considered for surgery and the original evaluation treatment plan is seemingly unrelated to these goals or to treatment of the diagnosed condition presented, which is a major depressive disorder. The treatment plan is not specific to the depressive disorder and is inconsistent with the rationale presented for the reconsideration and is not a necessary health service.

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

The secondary provider has suggested a diagnosis of MMD and secondary problems of maladjustment and disturbances in sleep and mood for which he requests 6 sessions of individual psychotherapeutic intervention using CBT approaches. According to ODG 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. MDD is a mental illness and which is typically manifested in phases - the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future. The diagnosis is difficult and guidelines recommend that the essential core of the diagnostic evaluation is the protocol provided in the American Psychiatric Association's diagnostic manual. (American Psychiatric Association, 2000) The diagnostician should compare the claimant's presentation to all of the information in that protocol, including diagnostic features, associated features and disorders, course, and differential diagnosis. It is noted that MDD is an episodic condition, not an ongoing state of general depression resulting from chronic pain. In any case, as noted by the prior review, the patient is working a 20 hour week and is being considered for a surgical intervention. The proposed treatment is not specific to the diagnosed depressive disorder and is inconsistent with the rationale presented for the reconsideration. I agree with the last reviewer that the reconsideration letter addressed treatment of chronic pain and not the diagnosis of MDD. As noted above, the gold standard for MDD treatment is a combination of antidepressant medication and psychotherapy. The records fail to document that the patient is taking antidepressant medication. The medical records fail to substantiate the request as

medically necessary. Therefore, my recommendation is to agree with the previous non-certification of the request for individual psychotherapy 1 x 6 weeks.

The IRO's decision is consistent with the following guidelines:

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

__X___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

The Official Disability Guidelines - Mental Disorders - August 13, 2008:

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)

Major Depressive Disorder

Warning: It is extremely difficult to credibly justify a claim of work-relatedness for Major Depressive Disorder. Subsequently, individuals who are treated within workers compensation for this disorder are going to be at an elevated risk of unjustifiably being exposed to the reliably detrimental health effects of involvement in workers' compensation. Scientific findings have reliably indicated that involvement in workers compensation leads to worse clinical outcomes (worse than the outcomes that are obtained when the treatment is delivered outside of the workers compensation system). (Rohling, 1995) (Binder, 1996) (Harris, 2005)

Major Depressive Disorder, definition

Warning: this is a highly summarized definition that is not intended to provide a full understanding of Major Depressive Disorder. It is instead simply intended to provide readers with a simple overview.

The American Psychiatric Association's diagnostic manual (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Text Revision. Washington, D.C., American Psychiatric Association, 2000) defines Major Depressive Disorder as a mental illness that is characterized by one or more Major Depressive Episodes without a history of Manic, Mixed, or Hypomanic Episodes (some details that will help to provide an understanding of what this definition means are provided below). (American Psychiatric Association, 2000) This mental illness is typically manifested in phases - the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future.

The "major depressive episodes" to which the above definition refers are the phases when the symptoms are present. These episodes are defined as: (1) a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities; (2) the individual also experiences at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep disturbance, psychomotor agitation or psychomotor retardation, decreased energy, feelings of worthlessness or guilt, difficulty thinking/concentrating/making decisions, recurrent thoughts of death or suicidal ideation/plans/attempts; & (3) the symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks.

The portion of the definition which reads "without a history of Manic, Mixed, or Hypomanic Episodes" serves to separate Major Depressive Disorder from the Bipolar and Cyclothymic Disorders.

Major Depressive Disorder, diagnosis:

The essential core of the diagnostic evaluation is the protocol provided in the American Psychiatric Association's diagnostic manual. (American Psychiatric Association, 2000) The diagnostician should compare the claimant's presentation to all of the information in that protocol, including diagnostic features, associated features and disorders, course, and differential diagnosis.

The following examples of issues from that protocol are not intended to serve as a substitute for the full protocol. These examples are only being provided in order to give readers some idea of what the protocol involves, and to at least partially convey the complex nature of the protocol.

MDD is characterized by a history of one or more Major Depressive Episodes. These episodes are phases when the symptoms are present for most of the day, nearly every day, for at least 2 consecutive weeks.

Diagnostic features for such major depressive episodes include:

A period of at least 2 weeks during which there is:
(1) a depressed mood, and/or
(2) the loss of interest or pleasure in nearly all activities;

At least four additional symptoms drawn from a list that includes:
(1) Changes in appetite or weight
(2) Sleep disturbance
(3) Psychomotor agitation (e.g., observable restlessness) or psychomotor retardation (e.g., observably moving more slowly than usual)
(4) Decreased energy
(5) Feelings of worthlessness or guilt
(6) Difficulty thinking/concentrating/making decisions
(7) Recurrent thoughts of death or suicidal ideation/plans/attempts

Course: This mental illness is typically manifested in phases - the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future.

Differential Diagnosis: The person with this disorder has not experienced any Manic, Mixed, or Hypomanic Episodes, (which would push the diagnosis toward the Bipolar and Cyclothymic disorders, instead of MDD). The symptoms cannot be attributed to any other mental illness, or to any general medical condition.

Psychological Tests (e.g., current editions of the Minnesota Multiphasic Personality Inventory, Battery for Health Improvement, Millon Clinical Multiaxial Inventory, Structured Interview of Reported Symptoms) can be used as an important adjunct to the diagnostic process, specifically for the purpose of introducing an objective element to a process that is otherwise completely subjective. (Bruns, 2001) (Butcher, 2004) (Millon, 2001) (Rogers, 1992)

Thorough Review of Claimant's History can ideally involve an examination of records from the claimant's entire life, and collateral reports. This thorough type of approach is preferable to relying on the report of the claimant, because scientific findings have consistently revealed that an examinee's report of his or her history is not a credible basis for clinical decision-making. (Barsky, 2002) (Lees-Haley, 1996) (Carragee, 2007)

Any such diagnostic evaluation (and associated treatment planning) should take place on an independent basis. (Barth, 2005) If the evaluation does not take place on an independent basis, then the clinician must avoid any discussion regarding forensic issues such as work-relatedness, disability, etc. (Barth, 2005)

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)

MAJOR DEPRESSIVE DISORDER - DEFINITION

Definition (not a procedure): The American Psychiatric Association's diagnostic manual (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Text Revision. Washington, D.C., American Psychiatric Association, 2000) defines Major Depressive Disorder as a mental illness that is characterized by one or more Major Depressive Episodes without a history of Manic, Mixed, or Hypomanic Episodes (some details that will help to provide an understanding of what this definition means are provided below). (American Psychiatric Association, 2000) This mental illness is typically manifested in phases - the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future. The "major depressive episodes" to which the above definition refers are the phases when the symptoms are present. These episodes are defined as: (1) a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities; (2) the individual also experiences at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep disturbance, psychomotor agitation or psychomotor retardation, decreased energy, feelings of worthlessness or guilt, difficulty thinking/concentrating/making decisions, recurrent thoughts of death or suicidal ideation/plans/attempts; & (3) the symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The portion of the definition which reads "without a history of Manic, Mixed, or Hypomanic Episodes" serves to separate Major Depressive Disorder from the Bipolar and Cyclothymic Disorders.

MAJOR DEPRESSIVE DISORDER - TREATMENT

Recommend using the protocol provided in the American Psychiatric Association's diagnostic manual as the essential core of the diagnostic evaluation. (American Psychiatric Association, 2000) The diagnostician should compare the claimant's presentation to all of the information in that protocol, including diagnostic features, associated features and disorders, course, and differential

diagnosis.
The following examples of issues from that protocol are not intended to serve as a substitute for the full protocol. These examples are only being provided in order to give readers some idea of what the protocol involves, and to at least partially convey the complex nature of the protocol. For example, the protocol specifies that MDD is characterized by a history of one or more Major Depressive Episodes, which are phases when the symptoms are present. These episodes are defined as: a period of at least 2 weeks during which there is a depressed mood and/or the loss of interest or pleasure in nearly all activities; the individual also experiences at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep disturbance, psychomotor agitation (e.g., observable restlessness) or psychomotor retardation (e.g., observably moving more slowly than usual), decreased energy, feelings of worthlessness or guilt, difficulty thinking/ concentrating/ making decisions, recurrent thoughts of death or suicidal ideation/plans/attempts; and the symptoms persist for most of the day, nearly every day, for at least 2 consecutive weeks. The person with this disorder has not experienced any Manic, Mixed, or Hypomanic Episodes, (which would push the diagnosis toward the Bipolar and Cyclothymic disorders, instead of MDD). This mental illness is typically manifested in phases - the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future. Some psychological tests (e.g., Minnesota Multiphasic Personality Inventory, Battery for Health Improvement, Millon Clinical Multiaxial Inventory, Structured Interview of Reported Symptoms) can be used as an important adjunct to the diagnostic process, specifically for the purpose of introducing an objective element to a process that is otherwise completely subjective. (Bruns, 2001) (Butcher, 2004) (Millon, 2001) (Rogers, 1992) In order to enhance the credibility of diagnostic findings, the claimant's history can be thoroughly reviewed. Such a review can ideally involve an examination of records from the claimant's entire life, and collateral reports. This thorough type of approach is preferable to relying on the report of the claimant, because scientific findings have consistently revealed that an examinee's report of his or her history is not a credible basis for clinical decision-making. (Barsky, 2002) (Lees-Haley, 1996) (Carragee, 2007) Any such diagnostic evaluation (and associated treatment planning) should take place on an independent basis. (Barth, 2005) If the evaluation does not take place on an independent basis, then the clinician must avoid any discussion regarding forensic issues such as work-relatedness, disability, etc. (Barth, 2005)