

Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 09/22/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy 1x6

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured at work on xx/xx/xx. At the time, she was performing her usual job duties. Claimant reports that she slipped and fell on water that was on the floor landing on her right shoulder and right wrist. She sustained a rotator cuff tear, which was repaired. She received surgery to her right wrist. She has attended post-operative physical therapy and has been prescribed Lyrica, Lortab, and Mobic. She was referred to a pain management specialist, but requested to postpone that referral for the present time.

Records indicate claimant has received the following diagnostics and treatments to date: x-rays, MRI (positive), surgery x 2, physical therapy, psychotherapy, and medications management. Current diagnoses include: right wrist strain/sprain,

right shoulder strain/sprain, S/P right rotator cuff repair, S/P right wrist surgery, and adhesive capsulitis, right shoulder.

Patient was referred her for a psychological evaluation to assess appropriateness for conservative individual therapy sessions. On 6/3/08, patient was interviewed and evaluated by , LPC, in order to make psychological treatment recommendations. Patient was administered the patient symptom rating scale, BDI and BAI, along with an initial interview and mental status exam. Results indicated that the patient had developed an injury-related adjustment disorder with mixed anxiety and depressed mood. Patient rated her average pain level as a 5/10VAS, stating it significantly interfered with her recreational, social, and family activities. Patient has no pre-existing history of psychological involvement. She endorsed both initial and sleep maintenance insomnia, sleeping 4-6 fragmented hours per night. Request for initial trial of 4 individual therapy sessions was approved, and current request is for an additional 6 sessions of cognitive- behavioral individual therapy. Goals are: improved mood, increased coping skills, improved problem-solving, and reduced muscle tension, anxiety, and sleep problems.

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

After only four sessions of individual therapy, following the ODG-recommended stepped-care approach, patient has been able to achieve the following gains: Decrease in perception of pain form 5/10 to 3/10, self-reported decreased irritability from 4/10 to 2/10, decreased family discord from 4/10 to 3/10, a 50% improved ability to decrease tension, improved sleep, and decreased depressed feelings from 4/10 to 3/10.

A stepped-care approach to treatment has been followed, as per ODG, and the requested evaluation and sessions appear reasonable and necessary to continue to treat the issues arising from the patient's injury-related pain and off-work status, with a goal of increased overall well-being and emotional functioning. Therefore, this request is considered medically reasonable and necessary at this time.

ODG Work Loss Data, 2008, Texas

Psychological evaluations: Recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in *subacute* and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. ([Main-BMJ, 2002](#)) ([Colorado, 2002](#)) ([Gatchel, 1995](#)) ([Gatchel, 1999](#)) ([Gatchel, 2004](#)) ([Gatchel, 2005](#))

CBT: 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)

Education (to reduce stress related to illness): Recommended. Patient education consisting of concrete, objective information on symptom management, including disease and treatment information, has been found to help reduce patient stress, especially when combined with emotional support and counseling. ([Rawl, 2002](#))

Psychotherapy for MDD: Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. ([American Psychiatric Association, 2006](#)) See also [Cognitive therapy](#) for additional information and references, including specific **ODG Psychotherapy Guidelines** (number and timing of visits).

Patient selection. Standards call for psychotherapy to be given special consideration *if* the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans which did not involve psychotherapy.

Types of psychotherapy. The American Psychiatric Association has published the following considerations regarding the various types of psychotherapy for MDD:

- Cognitive behavioral psychotherapy is preferable to other forms of psychotherapy, because of a richer base of outcome studies to support its use, and because its structured and tangible nature provides a means of monitoring compliance and progress.
- In contrast, psychodynamic psychotherapy is not recommended because it has specifically been identified as lacking scientific support, and is severely vulnerable to abuse because it can involve a lack of structure. ([American Psychiatric Association, 2006](#))

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)