



Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 8/2/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 90806 Individual Psychotherapy: Once a week for 6 weeks.

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

Texas licensed clinical psychologist.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for 90806 Individual Psychotherapy: Once a week for 6 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Texas Workers' Compensation Work Status Report dated 7/20/10.
- Doctors Report dated 6/14/10.
- Exam Results dated 7/10/10 x12.
- Adverse Determination After Reconsideration Notice dated 7/7/10, 6/8/10.
- Reconsideration: Behavioral Health Individual Psychotherapy Preauthorization Request dated 6/29/10.
- Post Surgical Report dated 6/29/10.
- Intervention Report dated 6/9/10.
- Treatment Plan Sheet dated 6/8/10.
- Behavioral Health Individual Psychotherapy Preauthorization Request dated 6/2/10.
- Follow Up Report dated 5/26/10, 4/20/10, 2/3/10, 1/13/10, 12/8/09, 10/27/09, 10/14/09.

- Treatment Re-Assessment & Discharge dated 5/26/10.
- Transportation/Lodging Documentation dated 5/19/10, 5/5/10, 4/21/10, 3/26/10, 3/19/10, 3/8/10, 3/1/10, 2/26/10, 2/19/10, 1/25/10, 1/20/10, 1/15/10, 12/14/09, 12/4/09, 10/16/09, 10/7/09, 9/17/09, 9/30/09.
- Individual Psychotherapy Note dated 5/14/10, 11/13/09, 9/17/09.
- Radiological Results dated 5/14/10.
- Radiology Report dated 4/9/10.
- Operative Report dated 4/2/10.
- Treatment Re-Assessment & Discharge dated 3/29/10, 1/26/10, 10/22/09.
- Chest X-Ray dated 2/9/10.
- History and Physical Examination dated 2/9/10, 11/18/09.
- Patient History dated 2/9/10.
- SOAP Sheet dated 1/27/10.
- Final Report dated 12/17/09, 8/27/09.
- Procedure Note dated 11/25/09.
- FCE Report dated 11/18/09.
- MMI Report dated 11/6/09.
- Prescription of Certification of Medical Necessity dated 10/30/09.
- Electrodiagnostic Results dated 10/15/09.
- Infrared-Video ENG dated 9/9/08.
- Biofeedback Training Note dated 9/30/09, 9/17/09.
- Initial Consultation dated 9/10/09.
- Addendum dated 8/31/09.
- Pre-MRI Questionnaire dated 8/27/09.
- Note for dated 9/1/09.
- Peer Review dated 8/3/09.
- Letter of Medical Necessity dated 7/27/09.
- Notice of Issue and Refusal to Pay Benefits dated 7/28/09.
- Drug Screen Urine dated 6/2/09.
- Hematology Report dated 6/2/09.
- Appointment Verification dated 6/2/09.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: An electrical shock caused him to fall backwards and hit his head, neck, and back.

Diagnosis: Major depressive disorder, single episode, severe without psychotic features (secondary to work injury); Cognitive disorder (secondary to work injury); Pain Disorder associated with both psychological features and a general medical condition (secondary to work injury).

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

This male sustained a work related injury to his head and upper back on xx/xx/xx, while performing his customary duties. The medical records indicated that the claimant was working in a building that had no roofing and it was raining. The claimant reported that he was welding some stairs when he felt an electrical shock that knocked him backwards causing him to fall on the ground onto his back and hit his head, neck and back and had no recollection of what happened after this, as he was unconscious for some time, only recovering consciousness when he was in an ambulance. The claimant's supervisor was notified. The claimant may have lost consciousness for 30 minutes and was taken to Hospital. His medical problems concerned spinal stenosis (surgery was done), spondylolisthesis, spondylosis, headache, and overall body pain. His mental health diagnoses included major depressive disorder, pain disorder, and cognitive disorder, all secondary to his industrial accident. He had received conservative care that had failed. In addition to conservative care, he had received surgery, pain management, and psychotherapy. He was referred by his treating physician to Dr., for a psychological evaluation. Dr.'s clinic, treatment protocols and outcomes were well known to this reviewer. Dr. began seeing the claimant for psychotherapy related to the accident (done by Dr. as well). The claimant appeared to have responded to psychotherapy and biofeedback, which was evidenced by reported lower scores on overall perceived pain intensity levels, on a scale of 0 being no pain and 10 being excruciating pain. He also reported lower levels of depressive and anxiety symptomology as measured by the Beck Depression Inventory (BDI) and the Beck Anxiety Inventory (BAI), after psychotherapy. He reported symptoms of sadness, tearfulness, lethargy, anxiety, short term memory loss with intermittent disorientation, dizziness, headache, personality changes, shocking sensation in entire body, loss of confidence, and mild symptoms suggestive of mild paranoia. He had an estimated 20 sessions of psychotherapy from Dr., who requested an additional 6 sessions of psychotherapy. Dr. diagnosed the claimant with depressive disorder, cognitive disorder and pain disorder, which in combination leads to a complex patient from any mental health standpoint. These disorders have the potential to exacerbate each other and must be treated aggressively. The ODG is clear in stating that treatment is warranted for patients of a complex nature who exhibit symptomology similar to this patient. *The use of a snapshot approach to status this patient's outcomes from psychotherapy is limited in nature and scope and does not allow enough data points to make a clear decision on future treatment needs.* Provider input is critical, as screening tool such as the BDI and the BAI cannot capture the total mental health picture of the claimant. This reviewer disagrees with past reviews and recommends overturning the previous adverse determinations. This reviewer recommends an additional 6 session of psychotherapy with continued documentation of functional improvement. The provider should determine the viability of termination of the claimant within these additional 6 sessions, if improvement is shown and the termination is ethical (no signs of suicide ideation, claimant not worse). The ODG for Head, Cognitive Therapy state that psychotherapy is "recommended with restrictions below. For concussion/ mild traumatic brain injury (TBI), neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under controlled conditions, and findings interpreted by trained clinicians.

Moderate and severe TBI are often associated with objective evidence of brain injury on brain scan or neurological examination (e.g., neurological deficits) and objective deficits on neuropsychological testing, whereas these evaluations are frequently not definitive in persons with concussion/mTBI. There is inadequate/insufficient evidence to determine whether an association exists between mild TBI and neurocognitive deficits and long-term adverse social functioning, including unemployment, diminished social relationships, and decrease in the ability to live independently. Attention, memory, and executive functioning deficits after TBI can be improved using interventions emphasizing strategy training (i.e., training patients to compensate for residual deficits, rather than attempting to eliminate the underlying neurocognitive impairment) including use of assistive technology or memory aids. (Cifu, 2009) Cognitive behavioral psychotherapy and cognitive remediation appear to diminish psychological distress and improve cognitive functioning among persons with traumatic brain injury (TBI) (McDonald, 2002), (Mittenberg, 2001) (Szymanski, 1992) (Tiersky, 2005) (Wood, 2004) For mild TBI, a referral for psychological services should be strongly considered three or more months post-injury if the individual is having difficulty coping with symptoms or stressors or when secondary psychological symptoms such as intolerance to certain types of environmental stimuli or reactive depression are severe. Treatment may include individual psychotherapy, marital therapy, group therapy, instruction in relaxation and related techniques, cognitive/behavioral therapy, social skills training and interventions/consultation in the community. (Colorado, 2005) There is a significant association between masculine role adherence and good outcomes among men with traumatic brain injury, but resistance to psychological help should still be discouraged. (Schopp, 2006) Psychological support services can help alleviate the distress that patients experience after traumatic brain injury and should be offered not only on a short-term basis, but for up to 2 years, according to the McGill Interdisciplinary Prospective Study. Even patients who do not require intervention in a rehabilitation setting on a long-term basis should be considered for psychological support services. (deGuise, 2008)

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)

Extremely severe cases of combined depression and PTSD may require more sessions if documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials. According to several reviews on Traumatic Brain injury, most notably, RT, JS, M, FM, JD, K. Depression after traumatic brain injury: a National Institute on Disability and Rehabilitation Research Model Systems multicenter investigation. Arch Phys Med Rehabilitation 2003; 84:177-84 found that patients with TBI are at great risk for developing depressive symptoms. Researchers Chamelian and Feinstein stated this summary in 2006, mild to moderate TBI patients with persisting subjective cognitive complaints have demonstrable evidence of cognitive dysfunction. In most, but not all patients, these objective cognitive difficulties are linked to comorbid major depression. This clinically important observation suggests that a

detailed assessment of mood based on objective criteria should be considered in all patients who complain of cognitive problems following such injuries.”

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Head, Cognitive therapy.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).

Seel RT, Kreutzer JS, Rosenthal M, Hammond FM, Corrigan JD, and Black K. Depression after traumatic brain injury: a National Institute on Disability and Rehabilitation Research Model Systems multicenter investigation. Arch Phys Med Rehabil 2003;84:177-84.

L. Chamelian and A. Feinstein. The Effect of Major Depression on Subjective and Objective Cognitive Deficits in Mild to Moderate Traumatic Brain Injury. J Neuropsychiatry Clin Neurosci, December 1, 2006; 18(1): 33 - 38

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).