

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 01/05/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Individual Psychotherapy 1xWk x 6Wks

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

Texas Board Certified Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinic notes from dated 09/24/09 and 09/30/09
2. Initial physical therapy evaluation dated 10/19/09
3. MRI of the cervical spine dated 10/21/09
4. Initial behavioral medicine consultation dated 10/26/09
5. Prior review dated 11/03/09
6. Letter of reconsideration dated 11/23/09
7. Prior review dated 12/02/09
8. Cover sheet
9. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury on x/xx/xx. A clinic note dated 09/24/09 reported the employee was injured while assisting in moving a very large female patient that began to fall. The employee attempted to catch the falling patient and experienced immediate hot, burning pain in her back and her shoulders. The note reported the employee then developed pain, numbness and tingling from her right and left buttocks radiating into bilateral lower extremities to about mid thigh, worse on the left than the right. Physical examination of the neck reported no myospasms and some tenderness to palpation. Physical examination of the thoracic spine reported decreased

range of motion and mild myospasms. Physical examination of the lumbar spine reported decreased range of motion, moderate myospasms, greater on the left, point tenderness over the bilateral SI joints, greater on the left, and negative bilateral straight leg raise. The employee was recommended for physical therapy.

A clinic note dated 09/30/09 reported the employee complained of pain in her neck, back, and left shoulder with numbness going down the bilateral lower extremities. Physical examination reported paravertebral spasming and tenderness in the cervical and lumbar spine, greater on the left, decreased cervical and lumbar range of motion, cervical and lumbar spine myospasms, positive left straight-leg raise, and decreased left shoulder range of motion. The employee was recommended for thirty day work restriction, physical therapy, MRI of the lumbar spine and cervical spine, electrodiagnostic study bilateral lower extremities, and medication management.

Initial physical therapy evaluation dated 10/19/09 reported the employee complained of left shoulder pain. Physical examination of the cervical spine reported the employee's range of motion was 51 degrees of flexion, 34 degrees of extension, 26 degrees of left lateral flexion, 28 degrees of right lateral flexion, 65 degrees of left rotation, and 56 degrees of right rotation. Physical examination of the employee's left shoulder reported decreased motor strength, 139 degrees of flexion, 40 degrees of extension, 141 degrees of abduction, 33 degrees of adduction, 82 degrees of external rotation and 85 degrees of internal rotation.

An MRI of the cervical spine dated 10/21/09 reported mild multilevel degenerative disc disease, a central to right paracentral small disc protrusion with some possible mild encroachment into the right neural foramina at the C5-C6 level with no central canal stenosis.

An initial behavioral medicine consultation dated 10/26/09 reported the employee complained of 6/10 pain in her mid and lower back that radiated into her bilateral lower extremities. The note reported the employee was currently taking Tramadol and Darvocet. The note reported the employee complains of difficulties with activities of daily living and insomnia. The note also reported that the employee was cooperative throughout the interview, oriented times four, intellectual functioning within normal limits, memory intact, dysthymic and anxious mood, constricted affect, and no evidence of hallucinations or delusions. The employee self-reported her sadness and depression as 1/10, irritability and restlessness as 5/10, frustration and anger 3/10, muscular tension/spasms 6/10, nervousness and worry 3/10, sleep disturbance 3/10, and forgetfulness and poor concentration 3/10. The note reported that the employee had a BDI-2 score of 12 indicating minimal depression and a BAI score of 16 indicating moderate anxiety. The employee was recommended for six sessions of individual psychotherapy.

Prior review by Dr. dated 11/03/09 found that the request for six sessions of individual psychotherapy was not medically necessary. The prior review indicated that the requested treatment was denied on the basis of the employee only being six weeks status post injury and not exhausting all conservative measures to date.

A letter of reconsideration dated 11/23/09 reported LPC believed the prior reviewer used the wrong guidelines to address the request. The note reported that the prior reviewer used **Official Disability Guidelines** pain chapter instead of **Official Disability Guidelines** mental illness and stress chapter. The note reported that the employee was not currently contending with a chronic pain condition, but was diagnosed with an adjustment disorder. The employee was once again recommended for six sessions of individual psychotherapy.

Prior review by Dr. dated 12/02/09 determined the request for six sessions of individual psychotherapy to not be medically necessary. The note reported the denial was based on the employee being status post three months from injury date, having mild anxiety and depression indicated on Beck's scales, and having not been placed on psychotropic medications.

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

According to the available medical records and the **Official Disability Guidelines**, the request for individual psychology 1xWk x 6Wks is not medically necessary at this time. Psychometric testing conducted in the initial behavioral medicine evaluation on 09/16/09 indicates the employee has mild symptoms of anxiety and depression. This reviewer agrees with the prior denial on the basis that the employee has mild symptoms on Beck's scales and has not been treated with psychotropic medications to date. The clinical documentation submitted for review did not indicate that the employee has been treated with any psychotropic medications to date. As such, the medical necessity for the request for individual psychology 1xWk x 6Wks has not been established at this time.

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

***Official Disability Guidelines*, Mental Illness and Stress Chapter**

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)