

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 06/28/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;

DATES OF SERVICE FROM 05/05/2010 TO 06/30/2010

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

Texas Licensed 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. Cover sheet and working documents
2. MMI/IR rating dated 07/30/09
3. Medical records Dr.
4. Chronic pain management program description
5. Functional Capacity Evaluation dated 09/14/09
6. Operative report dated 10/14/09
7. Medical records D.C.
8. Handwritten notes Dr. M.D.
9. BHI 2 interpretative report dated 11/20/09
10. Treatment progress report dated 12/10/09, 03/11/10
11. Chronic pain management program treatment goals and objectives dated 01/12/10
12. Physical Performance Evaluation dated 02/22/10

13. Chronic pain management program discharge summary report dated 05/03/10
14. Response to denial letter dated 05/07/10
15. Utilization review determination dated 05/07/10, 06/02/10
16. Peer review reports dated 05/05/10, 05/28/10
17. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female whose date of injury is xx/xx/xx. On this date she was trying to transfer a patient from a bed to a wheelchair and reported low back pain and right leg pain.

Treatment to date includes diagnostic testing, physical therapy, two epidural steroid injections, sixteen inpatient therapy sessions, surgical repair at L4-L5, L5-S1, decompression stabilization with L3-L4 laminectomy on 03/18/09, and revision lumbar spine surgery with removal of EBI transmitter on 10/14/09.

The employee was previously determined to have reached Maximum Medical Improvement (MMI) as of 05/06/09 with 10% whole person impairment.

The employee underwent a Functional Capacity Evaluation (FCE) on 09/14/09.

There was no initial psychological evaluation submitted for review, but treatment progress report dated 12/10/09 indicated that the employee had been diagnosed with low back pain, adjustment disorder with mixed anxiety and depressed mood, and pain disorder associated with a work related injury medical condition and psychological factors. Medications are listed as topical pain cream, Lidoderm patch and Benicar. The employee has completed sixteen sessions of individual psychotherapy. BDI had improved from 12 to 10 and BAI improved from 8 to 5.

The employee underwent a Physical Performance Evaluation (PPE) on 2/22/10 which indicated that the employee's current physical demand level was light and required a physical demand level of medium.

Most recently the employee completed a chronic pain management program. The chronic pain management program discharge summary report dated 05/03/10 indicated that the employee completed fifteen days of the program. Medications were topical pain cream, Lidoderm patch, Darvocet N-100, and Benicar. The employee was subsequently recommended to undergo six sessions of individual psychotherapy.

The request for six sessions of individual psychotherapy was non-certified on 05/07/10 noting that the employee recently completed a chronic pain management program and did show some progress. Following termination of the program the employee's depression and anxiety score reportedly increased. The employee had already undergone intense individual, group and pain counseling, and had responded to the counseling which suggested that she learned adequate tools to manage her pain, depression and anxiety. The reviewer noted that a return to individual psychotherapy may undermine the need for her to take responsibility for her pain management and

would foster dependence on the therapist. **Official Disability Guidelines** do not recommend individual psychotherapy beyond twenty visits.

An appeal letter dated 05/07/10 indicated that the employee was experiencing severe stressors during the last ten days of the program as she lost her place to live due to no finances and was informed that she could not dispute her impairment rating. The employee is working with DARS, and the letter indicates that the **Official Disability Guidelines** recommend follow up for at least three months for chronic pain patients.

The denial was upheld on utilization review dated 06/02/10. The employee had undergone a tertiary level program and was now working with DARS, but had not returned to work. **Official Disability Guidelines** specifically states that following completion of a chronic pain management program, the claimant should be considered to be at MMI and referred back to work or to a vocational rehabilitation program and recommends that previously completed medical rehabilitation to include IPO should not be repeated following completion of a chronic pain management program.

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

Based on the clinical information provided, the request for INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; DATES OF SERVICE FROM 05/05/2010 TO 06/30/2010 is not recommended as medically necessary.

The employee has completed sixteen sessions of individual psychotherapy followed by a chronic pain management program. The employee now reports signs and symptoms of depression and anxiety that are within normal limits. It is unlikely that the injured worker will benefit from further individual psychotherapy in as much as her symptoms appear to be within normal limits at this time.

Given the current clinical data, further INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT; DATES OF SERVICE FROM 05/05/010 TO 06/30/2010 is not indicated as medically necessary at this time.

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

The 2010 **Official Disability Guidelines**, 15th Edition, The Work Loss Data Institute, Mental Illness and Stress Chapter, Online edition

Cognitive therapy for depression	<p>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)</p> <p>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)</p>
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