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Notice of Independent Review Decision

DATE OF REVIEW: 03/15/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual Psychotherapy 1x/week for 6 weeks

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

Certified by the Texas State Board of Examiners of Psychologists

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	847.2	90806	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician order dated 1/15/10

Psychological testing results dated 12/30/09

Initial behavioral consultation dated 12/4/09 with addendum

Physician note dated 1/11/10

Official Disability Guidelines cited Low Back-cognitive behavioral therapy (CBT) guidelines for low back problems, cognitive therapy for depression

PATIENT CLINICAL HISTORY:

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The patient is a male whose date of injury is xx/xx/xx. On this date the patient was bending over to lift a box weighing approximately 100 pounds when he felt a pop in his back. Treatment to date includes diagnostic testing, 18-20 sessions of physical therapy and epidural steroid injection x 2. The patient reports that prior to the performance of a third epidural steroid injection, he had a minor heart attack. The patient underwent initial behavioral medicine consultation on 12/04/09. Medications are listed as Hydrocodone and Neurontin. The patient rates his pain as 7/10. The patient reports difficulty standing for long periods of time and difficulty sleeping. The patient was noted to ambulate as if bending forward, had difficulty getting in/out of sitting positions, grimaced several times and was tearful. Mood was dysthymic and affect constricted. The patient self-reported irritability and restlessness as 7/10; frustration and anger 8/10; muscle tension/spasm 8/10; nervousness and worry 7/10; sadness and depression 7/10; sleep disturbance 8/10 and forgetfulness 7/10. BDI is 37 and BAI is 20. Diagnoses are major depressive disorder, single episode, severe without psychotic features, secondary to the work injury; and pain disorder associated with both psychological factors and a general medical condition, secondary to the work injury.

The patient subsequently underwent psychological testing on 12/30/09. The results of the patient's MMPI-2-RF validity scales "raise concerns about the possible impact of over-reporting on the validity of this protocol". Scores on the substantive scales indicate somatic and cognitive complaints and emotional, thought, behavioral and interpersonal dysfunction. The patient reports feeling sad and is likely to complain of feeling depressed. He reports feeling anxious and is likely to experience significant anxiety and anxiety-related problems, intrusive ideation and nightmares. The patient also reports multiple fears that significantly restrict normal activity in and outside the home, and has a profound fear of pain, both emotional and physical. The patient reports a diffuse and pervasive pattern of somatic complaints involving different bodily systems including head pain, vague neurological complaints, and a number of gastrointestinal complaints. The patient reports a history of suicidal ideation and/or attempts and is likely to be preoccupied with suicide and death and to be at risk for current suicidal ideation and attempts. The patient's prognosis is generally poor "because he has little motivation for any type of psychological intervention". The patient's BHI-2 profile falls within that of patients who present themselves in an unusually negative manner with a high level of psychological and life problems. The patient reported having violent ideation. The patient's Content Area Profile is in the average range for the following scales: severe depression and helplessness, dysphoria, identity fragmentation, self-destructiveness, splitting, substance abuse history, suicidal ideation, and violent ideation. The patient was recommended to undergo psychotropic medication evaluation and 6 individual psychotherapy sessions.

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

In the Reviewer's opinion, based on the clinical information provided, the request for 6 sessions of individual psychotherapy is not considered medically necessary. The patient underwent psychological testing which raised concerns over the validity of the patient's subjective complaints. In order to disconfirm the validity issue noted with MMPI testing, the patient could

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have undergone TOMM testing, but there is no documentation that the patient was provided this test. Although the patient was recommended for psychotropic medication referral, there is no indication that the patient has been placed on antidepressant medication for treatment of depression.

References: ODG Mental Illness and Stress Chapter

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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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)