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Notice of Independent Review Decision

DATE OF REVIEW: August 16, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

90806 Individual psychotherapy 1 x 4 weeks

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

The reviewer is a licensed clinical psychologist who is a member of the American Psychological Association and International Neuropsychological Society. He is listed in the National Register of Health Service Providers in Psychology.

REVIEW OUTCOME

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

Overtured (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (07/20/11 – 08/01/11)

TDI

- Reviews (05/16/11 – 06/27/11)
- Office visits (06/29/11 – 07/29/11)
- Utilization reviews (07/20/11 – 08/01/11)

Insurance Company

- Reviews (05/16/11 – 06/27/11)
- Office visits (06/29/11 – 07/29/11)
- Utilization reviews (07/20/11 – 08/01/11)

Injury 1

- Office visits (06/29/11 - 07/29/11)
- Utilization reviews (07/20/11 – 08/01/11)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was running an errand at work and proceeding through an intersection in her car crossing a street when another vehicle T-boned her car striking the rear passenger side on xx/xx/xx. The force of the impact spun her car around. She was seat-belted and her seat was in full upright position. She sustained injuries to her head, neck, upper/mid back and bilateral shoulders.

Initially, the patient was evaluated by D.C., who diagnosed cervical, thoracic and bilateral shoulder sprain/strain secondary to MVA and recommended initiating physical therapy (PT) consisting of active and passive care program, obtaining x-rays of the cervical and thoracic spine and a second opinion by M.D., and medication management.

Dr. noted complaints of headache, neck pain, bilateral shoulder pain, upper back pain and right knee pain. He noted a history of chest injury at the age of 11 when a nail blew out of a lawnmower and hit her chest injuring ribs, stomach, heart and spleen; she had to undergo an open heart surgery to repair that injury. Two years back she had again gone to the emergency room (ER) for chest pain and had a cardiac angiogram done which did not reveal any coronary problems. Dr. diagnosed headache, cervical, thoracic and right knee sprain/strain; started Mobic and Norco and recommended PT.

X-rays of the thoracic spine revealed very mild scoliosis and very mild degenerative changes. X-rays of the right knee was unremarkable.

On February 26, 2011, the patient went to the ER for pain in the right leg/knee that increased with ambulation. She also complained of tingling and swelling in the left foot and calf. She was diagnosed with medial collateral ligament (MCL) sprain and treated with Advair and Vicodin. She was also provided knee brace and crutches and released to light duty work.

X-rays of the cervical spine revealed a grade I anterolisthesis of C4 on C5 of uncertain etiology. The cervical spine remained stable throughout the ROM from flexion to extension.

In April, an investigation report indicated that the patient was not injured in the accident occurring on xx/xx/xx. No impairment was noticed by the employer the day of the accident and she was still working at full salary. A witness at the accident site did not perceive that the patient was being injured and she did not tell the investigating officer at the scene of the accident or employer that she had been injured.

On April 19, 2011, D.C., stated the patient had not yet reached MMI as she had a life open medical on an as needed basis with her treating physician in order to avoid any further aggravation of her condition. Should her symptomatology increase in the future, follow-up consultation would be indicated. He also stated that the patient sustained a work-related injury when involved in the MVA sustaining injury to her neck, shoulders and right knee. She was currently expected to undergo rehabilitation program as she continued to work with

restrictions. He suggested re-evaluation for MMI/IR in approximately three months.

In April, Dr. started her on Soma for her neck spasms. The patient came in a right knee soft brace and pointed to the medial side of the knee as painful. From May 6, 2011, through May 18, 2011, the patient attended four sessions of consisting of therapeutic exercises, electrical stimulation, and moist hot packs.

In May, the patient returned to Dr. complaining of neck and bilateral shoulder pain. Palpation of the cervical spine revealed decreased mobility and fixations in the mid to lower cervical area with associated tenderness throughout bilaterally. There were muscular restrictions and adhesions resulting in decreased mobility in the bilateral scalenes and upper trapezius. Dr. recommended continuing light duty status pending completion of rehabilitation for the cervical, upper back, and right knee.

D.C., performed a peer review and opined as follows: (1) Based on the report from the designated doctor dated April 19, 2011, she sustained injury to the cervical spine, bilateral shoulders, and right knee from the accident of xx/xx/xx. (2) Chiropractic care rendered to date had been reasonable and necessary to treat any injury or condition that was causally related to the xx/xx/xx date of injury. PT for six sessions was within the guideline parameters. (3) The patient appeared to have exceeded the natural history without remarkable objective finding to support the protracted course of care.

M.D., performed a peer review and rendered the following opinions: (1) The injuries that were consistent with the motor vehicle accident were minor cervical sprain/strain and possible bilateral shoulder strain. The right knee injury (sprain) was ever more difficult to ascribe to the incident. (2) The compensable diagnosis appeared to be a cervical sprain/strain subjectively and presence of any type of MCL injury did not appear to be consistent. (3) There were no fractures of any of the areas x-rayed. (4) Reasonable and necessary care included an initial evaluation with a qualified physician for assessment of musculoskeletal and neurological baseline, up to nine sessions of formal PT, use of medications of an NSAID for up to three months as well as a muscle relaxant analgesic prescription and possibly and even a few weeks of a narcotic analgesic would be allowable post injury. However, by four weeks she should have been weaned from any muscle relaxant as well as narcotic analgesic. X-rays of the involved areas would have been allowable. (5) Office visits every four weeks until placed at maximum medical improvement (MMI), thereafter every four months if placed on medications. An RME with an orthopedic surgeon and an MRI of cervical spine were necessary. Hydrocodone and Soma be weaned over a four-week period. No injections and surgery were indicated. She had already returned to light duty.

M.D., diagnosed cervical strain and right knee sprain. Mobic, Norco and Soma were refilled and the patient was referred for psychotherapy.

In a behavioral medicine consultation, the patient endorsed both initial and sleep maintenance insomnia due to pain, decreased overall functioning, dysthymic and anxious mood, flat affect, irritability and restlessness. The patient scored a 20 on the Beck Depression Inventory (BDI-II) indicative of moderate depression, a 16 on the Beck Anxiety Inventory (BAI) indicative of moderate anxiety, a 21 on Fear

Avoidance Belief Questionnaire (FABQ-PA) indicative of fear avoidance of physical activity and also endorsed significant fear avoidance of work (FABQ-W=29). The psychologist recommended individual psychotherapeutic intervention for a minimum of four weeks to facilitate a health adjustment and improve coping with overall condition and reduce disturbances in mood and resolve psychosocial stressors.

Dr. reviewed the computerized tomography (CT) scan of the right knee which revealed a probable small tear of the posterior horn of the medial meniscus and moderate focal bone marrow edema involving the inferior proximal tibia. CT scan of the cervical spine revealed mild spondylosis at C5-C6. Therapy for right knee was recommended.

Ph.D., denied the request for psychotherapy 1 x 4 weeks based on the following rationale: *"There is no evidence that these psychological symptoms constitute a delay in the "usual time of recovery" from this acute injury (Work Loss Data Institute, ODG 2011). The patient is experiencing acute pain from the injury (5 months old). Guidelines state that "in patients with chronic pain psychological reactions become the major contributors to impaired functioning". However, with acute pain, "pain is still related to tissue damage" and "is not yet compounded by the motivational, affective, cognitive, and behavioral overlay that is often a frustrating aspect of chronic pain" (ACOEM Guidelines, Chapter 6). This is a new injury {5 month old) with acute pain. The patient is actively involved in the continued evaluation and treatment of this new injury. The patient has had recent PT sessions with no report of lack of progress and the patient has returned to work. At this time, there is no reason to believe that the current active rehabilitation will be insufficient to restore functional status. The evaluation does not identify specific behavioral or psychological findings that suggest risk factors for delayed recovery or chronicity. There is no evidence that these reported psychological symptoms constitute a delay in the "usual time of recovery" from this acute injury, thus requiring the requested treatment. There is no evidence that this patient is "at risk" for delayed recovery. The request is not consistent with the requirement that psychological treatments only be provided for "an appropriately identified patient". Based on the documentation provided, ACOEM and ODG criteria were not met. It is recommended that the request for individual psychotherapy x 4 is not reasonable or necessary"*.

On July 25, 2011, Ph.D., opined the patient was at a risk for delayed recovery as her injury was close to being six months old and she had been diagnosed with a cervical/right knee sprain/strain. The four psychotherapy sessions were requested to help reduce fear avoidance behaviors which might be affecting her physical therapy outcomes. Other goals of treatment were to help reduce her pain by teaching her relaxation techniques, help her gain insight into her pain and pacing herself at work and to help reduce her depression/anxiety/improve her sleep. Dr. Khan issued a prescription for psychotherapy evaluation and treatment.

On August 1, 2011, M.D., denied the request for psychotherapy 1 x 4 weeks based on the following rationale: *"The clinical indication and necessity of this procedure could not be established. The mental health evaluation of July 6, 2011 finds impression of pain disorder, acute. However, the utilized psychometric instruments are inadequate/inappropriate to elucidate the pain*

problem, explicate psychological dysfunction, or inform differential diagnosis in this case; and there is no substantive behavior analysis to provide relevant diagnostic information. The employed psychological tests do not have established peer reviewed, post-market reliability, validity (concurrent or predictive), and normative data to render appropriate sensitivity and specificity for assessment and diagnosis of patients with this type of presentation. Therefore, this renders the interpretations questionable; they do not serve as a basis for informing differential diagnosis; and an inflated estimate of reported distress and disability may be inferred. Appropriate treatment cannot be based on inadequate evaluation, i.e., "Mental health science is primarily categorized by diagnosis, therefore a credible diagnostic Formulation is of the greatest importance for evaluation and treatment planning. Dr. suggests that the patient presents as a "delayed recovery," but there is no documentation, and no other data now provided, of specific, antecedent or current psychosocial risk factors predictive of a "delayed recovery" or risk of chronicity in this case, thus requiring psychological or behavioral services to prevent, resolve or reduce. Though PT has been provided for the neck complaints, there is no indication that the prescribed and imminent physical therapy for the knee will be inadequate to restore pre-morbid or reasonable functional status, i.e., at this time there is no evidence of "lack of progress from PT," as a required indication for psychotherapy in this type of case. The above issues were not adequately addressed in the appeal letter of July 25, 2011, nor in today's consultation. Therein, the offered purpose of the psychotherapy to "reduce fear avoidance behaviors" is wholly unsupported. There is no convincing evidence for the effectiveness of cognitive-behavioral or other psychotherapeutic strategies, per se, in reducing the hypothesized "fear-avoidance". ODG Guidelines suggest only to "Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs" and that "'at risk' patients should [receive] physical therapy for exercise instruction, using a cognitive motivational approach to PT." [which is apparently pending]. There are no provisions for the use of psychotherapy to specifically modify any inferred "fear avoidance" beliefs. Current evidence is that"... it is the learned behavior restrictions which are reinforced by activity avoidance and for which 'fear' is the subjective covariate that are likely etiologic. Reducing fear avoidance alone has also not been shown to be causally related to recovery, and it is not yet clear what the best therapeutic strategies are. However, there is also no behavior analysis to explicate any learned behavior restrictions in this case. The stated goals relating to pain management (e.g., "reduce her pain;1) or "coping" and control of diagnosed emotional and behavioral sequelae of the pain problem are not empirically supportable. This focus is specifically proscribed in this type of patient because such a strategy "may reinforce psychological, environmental, and psychosocial factors" that promotes "chronic pain states." These factors have not been ruled out by the current evaluation. Per all the above, the patient is not an "appropriately identified patient" for whom psychotherapy is both reasonable and necessary at this time. The requested psychotherapy 1x4 is denied."

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

The claimant suffered multiple injuries in a motor vehicle accident in xx/xx. She has been treated conservatively, however her pain persists and she is reportedly unable to return to work. A psychological evaluation identified pain, as well as

symptoms of anxiety and depression. Four (4) sessions of individual psychotherapy were requested to decrease the probability of developing a chronic pain disorder and to treat her symptoms of anxiety and depression. The request was denied because the reviewer noted that the claimant was not suffering a chronic pain disorder and that her pain was in the acute stage and thus individual psychotherapy for treating the pain was not medically necessary per the ODG or ACOEM. The denial was appealed and the original denial was upheld because the evaluation did not clearly delineate the claimant's psychological diagnosis and there is no evidence that psychotherapy would effectively treat fear avoidance behavior. I disagree with the findings of the review in that they do not address the ODG's position on the medical necessity of individual psychotherapy in treating depression and anxiety.

ODG Psychotherapy Guidelines: 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). (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)

Beck, A., Rush, A. J., Shaw, B. F., & Emery, G. (1979) COGNITIVE THERAPY OF DEPRESSION. New York: The Guilford Press.

□ Cognitive therapy is an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders (for example, depression, anxiety, phobias, pain problems, etc.). □ pg. 3

□ Interventions utilizing behavior therapy, cognitive behavior therapy, and interpersonal therapy have all yielded substantial reductions in scores on the two major depression-rating scales and in a percentage of patients meeting MDD criteria post treatment; all three have also produced significant maintenance of effect after discontinuation of treatment. □ Summary of Treatments That Work (pp. xvii). In A GUIDE TO TREATMENTS THAT WORK. (pp. 593-609). Nathan, P. E. & Gorman, J. M. Oxford University Press: New York.

The psychological evaluation of the client indicated symptoms consistent with anxiety and depression for which the ODG represents that individual cognitive behavioral psychotherapy is a medical necessary treatment. The issue of whether the claimant was suffering chronic or acute pain would not modify the medical necessity of the requested treatment for the claimant's depression and anxiety.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES