

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 17, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy w/medication mgmt x12 sessions (90807, 90862)

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

This reviewer is a Board Certified Physical Psychiatrist with 20 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

In November 2009, the claimant underwent an Initial Psychiatric Assessment. The claimant demonstrates: problems related to the social environment,

occupational problems, economic problems, and problems with access to health care services. GAF: 60. Diagnosis: PTSD.

In November 2009, the claimant was re-evaluated.

In December 2009, the claimant was re-evaluated.

In January 2010, the claimant was re-evaluated.

In January 2010, the claimant underwent surgical intervention of the left femur. Procedures: 1. Treatment of the left severe femoral nonunion with autogenous bone, left femur. 2. Reamer, irrigator, aspirator, bone harvest, right femur, complex.

In February 2010, the claimant was re-evaluated.

In April 2010, the claimant was re-evaluated.

In June 8, 2010, the claimant was re-evaluated.

In November 2010, physician performed a utilization review on the claimant Rational for Denial: Guidelines allow for six sessions over 6 weeks and up to 20 visits of individual sessions with evidence of functional improvement. The documentation submitted for review was mostly unreadable secondary to copy quality and handwriting, however it did not appear that there was any type of objective psychometric testing to indicate improvement of the patient's psychological health. Therefore, it is not certified.

There is a letter dated November 2010, M.D. stating that patient was involved in a serious motor vehicle accident which he was rendered unconscious. With his extended hospitalizations and surgeries he developed major depressive episodes that have responded to Cymbalta and psychotherapy. He continues to have a severe amount of stress and remains limited to manage his independent activities of daily living. Psychiatric care at least quarterly for monitoring is recommended as he is at high risk for relapse of depression.

In December 2010, a psychiatrist performed a utilization review on the claimant Rational for Denial: Claim review indicates the claimant has completed at least seen individual psychotherapy visits to date, with measure improvement noted. The psychiatrist provided opined that it is the standard of psychiatric care to see a patient like this at least quarterly for monitoring as he is at high risk for relapse of depression. ODG notes that the treatment of severe presentation of MDD is recommended in the form of psychotherapy is combination with medication in an initial trial of 6 visits over 6 weeks. Absent further detailed documentation of the claimant's response to his previous 7 sessions to dated, the medical necessity of

additional psychotherapy treatment is not established. Therefore, it is not certified.

In December 2010, the claimant was evaluated. His incision is well healed, he is able to be in a removable wrist brace. Work on gentle range of motion.

In January 2011, the claimant was evaluated. AP and lateral of the entire length of the femur show excellent maintenance of reductions with solid fixation. His distal tibial nonunion is healed. His main problem is knee pain. He is there to discuss replacement arthroplasty as opposed to knee fusion

PATIENT CLINICAL HISTORY:

In xxxx, the claimant was involved in a serious automobile accident.

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

The previous decisions are upheld. First, many of the medical records submitted are handwritten and unreadable. Secondly, there is no documentation of improvement from the claimant's previous 7 sessions; therefore, without documentation of improvement the request for additional sessions is not certified.

ODG for Psychotherapy for Major Depressive Disorder:

Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. ([American Psychiatric Association, 2006](#)) See also [Cognitive therapy](#) for additional information and references, including specific **ODG Psychotherapy Guidelines** (number and timing of visits).

Patient selection. Standards call for psychotherapy to be given special consideration *if* the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans which did not involve psychotherapy.

Types of psychotherapy. The American Psychiatric Association has published the following considerations regarding the various types of psychotherapy for MDD:

- Cognitive behavioral psychotherapy is preferable to other forms of psychotherapy, because of a richer base of outcome studies to support its use, and because its structured and tangible nature provides a means of monitoring compliance and progress.

- In contrast, psychodynamic psychotherapy is not recommended because it has specifically been identified as lacking scientific support, and is severely vulnerable to abuse because it can involve a lack of structure. ([American Psychiatric Association, 2006](#))

Models of Psychosocial Rehabilitation Services:

(1) Self-Care and Independent Living Skills Techniques

- While social rehabilitative therapies (i.e., teaching social, coping, and life function skills) have been proven effective in chronic schizophrenic and other persistently impaired psychiatric cohorts, they have yet to be formally tested with PTSD clients. Since they appear to generalize well from clients with one mental disorder to another, it is reasonable to expect that they will also work with PTSD clients. There is clinical consensus that appropriate outcomes would be improvement in self-care, family function, independent living, social skills, and maintenance of employment.

- Given the positive impact of independent skills training techniques for mental disorders in general, PTSD-centered modules should be developed and tested for effectiveness. ([Halford, 1995](#))

(2) Supported Housing

- Forms of housing considered more effective are those in which clinical services are integrated or efforts are made by treating staff to foster community living. ([Goldfinger, 1997](#)) ([Schutt, 1992](#))

- Existing literature for persons with other forms of mental illness demonstrates that case management linked to specialized clinical services is more effective than “single-room occupancy” or “warehousing” in shelters without other forms of support. ([Goldfinger, 1997](#))

(3) Marital/Family Skills Training

- Marital and family treatments for trauma survivors fall into one of two general categories: systemic approaches designed to treat marital or family disruption, and supportive approaches designed to help family members offer support for an individual being treated for PTSD. These treatments are usually provided as an adjunct to other forms of treatment that are designed to directly address the PTSD symptoms.

- A single, low-quality RCT compared the addition of family therapy to individual therapy for war veterans with PTSD. ([Glynn, 1999](#)) It found no significant benefit to the addition of behavioral family therapy (BFT), largely due to a high dropout rate, nor did it add significantly to the treatment of PTSD with direct therapeutic exposure (DTE) (an individual psychotherapy technique).

- There are no research studies on the effectiveness of marital/family therapy for the treatment of PTSD. However, because of trauma's unique effects on interpersonal relatedness, clinical wisdom

indicates that spouses and families be included in treatment of those with PTSD. Of note, marriage counseling is typically contraindicated in cases of domestic violence, until the batterer has been successfully (individually) rehabilitated.

(4) *Social Skills Training*

- Effectiveness of social skills training has been well demonstrated over many years in many RCTs but not specifically for PTSD. ([Dilk, 1996](#))
- Effectiveness of social skills training has been demonstrated for reducing social isolation of persons with severe mental disorders (e.g., schizophrenia); similar techniques may be promising for PTSD, particularly if adapted to address antecedent conditions involved in trauma and its consequences. ([Rothbaum, 1996](#))

(5) *Vocational Rehabilitation*

- Effectiveness of vocational rehabilitation techniques in treating mental disorders has been demonstrated under controlled experimental conditions ([Bell, 1996](#)) ([Bell, 1993](#)) ([Bond, 1997](#)) and controlled, clinical studies. ([Anthony, 1995](#)) ([Drake, 1996](#)) ([Lehman, 1995](#)) ([Lysaker, 1993](#))

(6) *Case Management*

Although case management has been shown to be useful for a range of other psychiatric disorders, there is currently no evidence available from RCTs or from systematic reviews to support or reject the use of case management for PTSD patients.

- Among populations with histories of trauma, the assertive community treatment models have been empirically validated under controlled (but not with random assignment) conditions. ([Mueser, 1998](#))
- Most of the research that empirically validates case management has been conducted among persons with severe mental disorders, presumably including persons with co-occurring PTSD and other disorders. ([Mueser, 1998](#))
- Evidence suggests that outcomes are more favorable for intensive case management (well-trained clinician teaches client psychosocial rehabilitation skills in the client's home/community) than for simple case management (clinician links client to needed services).
- Case management has been demonstrated to reduce inpatient hospitalizations and severe symptoms, as well as to stabilize housing for formerly homeless persons; however, there is little evidence to suggest that case management improves vocational adjustment/social functioning. ([Mueser, 1998](#))

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)