



Notice of Independent Review Decision

DATE OF REVIEW:

04/22/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Six sessions of individual psychotherapy.

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

Board Certified Psychologist

REVIEW OUTCOME

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

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.

Six sessions of individual psychotherapy is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a female with an injury date of xx/xx/xx (xx years ago). She has apparently participated in substantial medical care/intervention and completed surgery in 1998. She is currently utilizing medication to manage refractory pain including Lyrica, Flexeril, Lovastatin, and Gemfibrozil.

It is noted in submitted documentation that there has been no active treatment recently. In the UR report submitted to the requesting physician, it was also noted that the injured individual was working 25 hours per week currently and caring for a disabled son. She has not had active treatment since 2007 and is working according to UR letters submitted to Dr.. No rebuttal was provided by Dr..

The request for six sessions of individual psychotherapy was accompanied by a Psychosocial Evaluation dated 03/14/2011. This evaluation was completed by a Licensed Social Worker. It was noted that the injured individual's husband died four years ago. She has had a hard-time and has lost two of her children. She has an impoverished educational background (6th grade) and was educated in Mexico. A past history of treatment for anxiety was noted.

In this report the injured individual reported that she was depressed. She completed a number of self-report inventories which provided evidence of fear of physical activity, depression, and anxiety. Mental status examination results were positive for flat affect, anxiety, and pain. No impairment in general mental status was noted. It is alleged that the injured individual is depressed and her depression is related to refractory pain. It is not known if she previously had counseling related to this accident.

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

Based on the submitted clinical documentation a credible psychological diagnosis is not substantiated related to changes in mental status after a work-related injury xx years ago. Only self-report screening inventories were administered by a social worker. These inventories have high sensitivity but very low specificity. They are not considered adequate to establish the presence of a mental health condition related to a work injury. No DSM-IV TR diagnosis was listed in the social worker's report. An insufficient evaluation was completed to develop a differential diagnosis and establish that the proximate cause of the injured individual's current distress is related to a work injury which occurred in xxxx.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines Treatment in Worker's Compensation, Online Edition

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)

Extremely severe cases of combined depression and PTSD may require more sessions if

documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials. Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders. (Leichsenring, 2008)

Chapter: Mental Illness and Stress

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)

Psychotherapy for MDD (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)