

Notice of Independent Review Decision (Amended)

DATE OF REVIEW: 04/16/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Psych 6x 90806

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

The physician performing this review is Board Certified, American Board of Psychiatry and Neurology and has been in practice since 1992 and is licensed in the State of Texas. Also a Member of: NADD National Association for the Dually Diagnosed, American Medical Association, Brain Injury Association of America and American Neuropsychiatric Association

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.

Medical necessity does not exist for 6 psychotherapy sessions for a diagnosis of Adjustment disorder

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 16 page fax 03/26/12 IRO request, 76 page fax 03/27/12 URA response to disputed services including administrative and medical records. 33 page fax 03/26/12 Provider response to disputed services including administrative and medical records. Dates of documents range from 07/01/11 to 3/26/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

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The claimant is a male who suffered a work-related lower back injury on xx/xx/xx. His treatment was conservative and included medications and physical therapy. A psychological examination dated 01/21/12 led to a diagnosis of Adjustment Disorder, Partner Relational Problem and Occupational Problem. Six individual psychotherapy sessions were requested and denied. The denial was later upheld.

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

Diagnostic precision is fundamental when referencing treatment guidelines such as the ODG. Evidence based medicine depends on a narrowly defined diagnosis for the purposes of inter-study comparison. Recommendations for the treatment of Adjustment Disorder do not exist in that ODG. Specific recommendations for Major Depression do exist in the ODG. There is evidence to support the use of individual psychotherapy for major depression. Depressive symptoms must be of sufficient severity to result in insomnia, amotivation, feelings of decreased self-worth, agitation or retardation, changes in appetite, cognitive inefficiency, recurrent thoughts of death, and loss of pleasure in most things for most of each day for at least two weeks in order to qualify for a diagnosis of major depression. The thorough psychiatric evaluation performed on 01/21/12 documents that in the case of criteria for a diagnosis of major depressive disorder may have been met but the diagnosis has not yet been formally assigned. In addition, depressive symptoms which extend to a pervasive syndrome meeting criteria for a formal psychiatric diagnosis, are not contingent upon the original circumstances which led to the disorder. In other words, treatment for major depression may be classified as a separate condition from the adjustment depression which may originate in the context of an acute bodily injury even if it originated as a result of the acute bodily injury. Evidence does exist for the use of individual psychotherapy for the treatment of major depression. In the current case, the request for six psychotherapy sessions for the treatment of major depression is reasonable and prudent, but recommendations for the treatment of Adjustment Disorder do not exist in that ODG therefore the previous adverse determination is upheld.

ODG

Description: A single episode of excessively long or intense sadness or extreme apathy. Other symptoms may include irritability, poor concentration, decreased appetite, social withdrawal, and an inability to experience pleasure.

Other names: Depression

Endogenous depression, single episode or unspecified

Manic-depressive psychosis or reaction, depressed type, single episode or unspecified

Monopolar depression, single episode or unspecified

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Excludes:

depression NOS ([311](#))

reactive depression (neurotic) ([300.4](#))

ODG Excludes:

acute reaction to major stress with depressive symptoms ([308.0](#))

affective personality disorder ([301.10](#)-[301.13](#))

affective psychoses ([296.0](#)-[296.9](#))

brief depressive reaction ([309.0](#))

depressive states associated with stressful events ([309.0](#)-[309.1](#))

mixed adjustment reaction with depressive symptoms ([309.4](#))

neurotic depression ([300.4](#))

prolonged depressive adjustment reaction ([309.1](#))

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](#))

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)

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)