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Notice of Independent Review Decision

DATE OF REVIEW: 12/19/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: CPT 4 individual psychotherapy sessions 90806

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

Texas Board Certified Family Practice

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Cover sheet and working documents
2. Employer's first report of injury or illness dated xx/xx/xx
3. Radiographic report left hand dated 08/11/11
4. Radiographic report left wrist dated 10/26/11
5. History and physical dated 08/22/11
6. Follow up note dated 09/01/11, 10/10/11, 09/19/11, 09/29/11, 10/06/11, 10/26/11, 11/07/11
7. EMG/NCV dated 10/06/11
8. Initial behavioral medicine consultation dated 09/01/11
9. Follow up rehab evaluation dated 10/07/11, 11/02/11
10. Utilization review determination dated 10/19/11, 11/15/11
11. Physical rehabilitation progress note dated 10/17/11, 10/18/11, 10/19/11, 10/24/11, 11/01/11, 10/25/11, 11/03/11
12. Environmental intervention note dated 10/18/11
13. Postoperative visit dated 10/04/11

14. Report of maximum medical improvement/impairment dated 09/13/11
15. New patient history and physical examination dated 09/15/11
16. CT left wrist dated 09/16/11
17. MRI lumbar spine dated 09/16/11
18. Letter dated 09/20/11
19. Initial rehab evaluation dated 09/21/11
20. Operative report dated 09/23/11
21. ***Official Disability Guidelines***

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male whose date of injury is xx/xx/xx. On this date the employee fell through an attic ceiling, landing on his back and his left hand.

X-rays of the left hand dated xx/xx/xx revealed a fracture of the carpal scaphoid bone.

History and physical dated 08/22/11 indicates that impressions include lumbar sprain/strain, rule out lumbar herniated disc, right lumbar radiculopathy, left wrist fracture and left wrist sprain/strain.

An initial behavioral medicine consultation dated 09/01/11 indicated that the employee reported difficulty sleeping. BDI is 11 and BAI is 12. The diagnosis is pain disorder associated with both psychological factors and a general medical condition, acute.

Report of Maximum Medical Improvement/impairment dated 09/13/11 indicated that the employee was working light duty with a split cast on the left wrist. The clinical impression is fracture left scaphoid and lumbar strain. The employee was determined not to have reached MMI. The employee subsequently underwent ORIF left scaphoid fracture on 09/23/11 followed by a course of postoperative physical therapy. EMG/NCV dated 10/06/11 notes that there is electrodiagnostic evidence that suggests but does not confirm a bilateral lumbosacral radiculopathy at L5.

The initial request for individual psychotherapy was non-certified on 10/19/11 noting that the psychological evaluation on 09/04/11 indicated the employee was experiencing minimal depressive symptoms and mild symptoms of anxiety. The request is inconsistent with the specification "identify patients who continue to experience pain and disability after the usual time of recovery". The evaluation reports a history of drug and alcohol use. This was unknown to Dr. and the substance abuse history was not assessed or addressed in the current evaluation. 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.

The denial was upheld on appeal dated 11/15/11 noting that there was no evidence that these minimal to mild psychological symptoms constitute a delay in the "usual time of recovery" from this acute injury. There was no evidence that this employee is "at risk" for delayed recovery.

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

Based on the clinical information provided, the request for 4 individual psychotherapy sessions is not recommended as medically necessary. The employee underwent behavioral medicine consultation on 09/01/11, less than one month after the date of injury. The evaluation documents minimal symptoms of depression and anxiety as evidenced by Beck scales. As noted by the previous reviewers, there is no reason to believe that the current active rehabilitation will be insufficient to restore functional status. There is no indication that the employee presents with significant psychosocial issues which have impeded his progress in treatment completed to date. There is no indication that the employee has been placed on psychotropic medications. The evaluation does not identify specific behavioral or psychological findings that suggest risk factors for delayed recovery or chronicity. Given the current clinical data, the request for individual psychotherapy is not indicated as medically necessary.

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

Official Disability Guidelines Mental Illness and Stress Chapter

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,
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[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)