

**IRO REVIEWER REPORT TEMPLATE -WC**

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**INDEPENDENT REVIEWERS OF TEXAS, INC.**

4100 West Eldorado Pkwy' Suite 100 -373 . McKinney, Texas 75070  
Office 469-218-1010 . Toll Free Fax 469-374-6852 e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

**Date notice sent to all parties:**

September 20, 2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

“COSA” Individual Psychotherapy X 6 sessions

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

Board Certified Chiropractic Examiner

**REVIEW OUTCOME:**

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

X Upheld                      (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Cover sheet and working documents  
Utilization review determination dated 08/21/12, 08/13/12

Radiographic report dated 05/10/12  
MRI lumbar spine dated 05/12/12  
MRI thoracic spine dated 06/20/12  
Office visit note dated 06/25/12, 07/25/12, 05/08/12, 08/09/12  
Chiropractic note dated 05/08/12-07/09/12  
Mental health evaluation dated 07/11/12  
Case management/spine x-ray conference note dated 07/19/12  
EMG/NCV dated 06/26/12  
Operative report dated 07/13/12

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female. On this date the patient was transferring a patient who was on a stretcher when she noted the acute onset of lower thoracic and upper lumbar pain. Treatment to date includes diagnostic testing, chiropractic treatment and bilateral L1 and L2 medial branch block on 07/13/12. Mental health evaluation dated 07/11/12 indicates that current medications are Nucynta, Flexeril and Lortab. Mood was anxious and dysphoric, but her affect was full range and appropriate. Diagnoses are pain disorder associated with both psychological factors and a general medical condition; and adult attention deficit disorder.

Initial request was non-certified on 08/13/12 noting that the patient has undergone extensive conservative and chiropractic treatment without sustained improvement. The claimant has developed disability behaviors and a chronic pain syndrome. The claimant was referred for a mental health evaluation on 07/11/12. This was a cursory evaluation that did not include any formal testing such as BDI, BAI or MMPI-II to support the diagnosis and treatment recommendation.

### **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 individual psychotherapy x 6 sessions is not recommended as medically necessary, and the two previous decisions are upheld. There is no indication that the patient presents with psychological issues which have impeded her progress in treatment completed to date. The submitted mental health evaluation does not provide any psychometric testing measures to support the patient's diagnosis and treatment recommendation. The patient is not currently taking any psychotropic medications. Given the current clinical data, the requested individual psychotherapy is not indicated as medically necessary.

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

**X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

#### REFERENCES:

Official Disability Guidelines Mental Illness and Stress Chapter

Cognitive therapy for depression	<p>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). (<a href="#">Paykel, 2006</a>) (<a href="#">Bockting, 2006</a>) (<a href="#">DeRubeis, 1999</a>) (<a href="#">Goldapple, 2004</a>) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (<a href="#">Gloaguen, 1998</a>) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (<a href="#">Thase, 1997</a>) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (<a href="#">Corey-Lisle, 2004</a>) 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. (<a href="#">Pampallona, 2004</a>) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (<a href="#">Royal Australian, 2003</a>) 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. (<a href="#">Warren, 2005</a>) Delivering cognitive behavioral therapy (CBT) by telephone is as effective as delivering it face-to-face in the short term, and telephone therapy is safe and has a higher patient retention rate. The attrition rate from psychotherapy can exceed 50% due to time constraints, lack of available and accessible services, transportation problems, and cost. Significantly fewer participants receiving telephone CBT discontinued their therapy than did those receiving face-to-face CBT. Both treatment groups showed significant improvement in depression, and there were no significant treatment differences when measured at posttreatment between telephone and face-to-face CBT. However, face-to-face CBT was significantly superior to telephone CBT during the follow-up period. The RCT used 18 sessions of either telephone CBT or face-to-face CBT. (<a href="#">Mohr, 2012</a>)</p> <p><b>ODG Psychotherapy Guidelines:</b> 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)</p>
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