

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: December 2, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual Psychotherapy 1 x a week x 4 weeks

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

The Reviewer is a Licensed Psychologist with over 25 years of experience.

REVIEW OUTCOME:

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

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:

05-10-13: Medical Record Review

08-29-13: Initial Office Visit Note

10-09-13: Pre-Surgical Psychological Evaluation

10-12-13: Follow-up

10-17-13: UR performed

11-04-13: Reconsideration: Behavioral Health Individual Psychotherapy
Preauthorization Request

11-11-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured at work on xx/xx/xx when he fell backwards. He reported immediate severe low back pain with radiation into his left leg. A lumbar MRI from 07/16/13 showed a disc herniation at L5-S1 on the left side with foraminal encroachment. There was a central annular tear or bulging at the L4-5 level. Prescriptions have included meloxicam, cyclobenzaprine, tramadol, naproxen, Cymbalta, and flexeril. Treatment included chiropractic rehabilitation. Injections were recommended but denied. He was also referred for a

psychological evaluation and rehabilitation. An MMPI-2 done on 2/19/13 by an LPC identified somatization, preoccupation with symptoms, and depression. He underwent 3 sessions of psychological counseling in March 2013.

08-29-13: Initial Office Visit Note. Chief Symptoms: Back and severe left leg pain. Physical Examination: ROM was guarded and restricted, gait antalgic. Knee jerks were normal; ankle jerks were trace to absent. There was hypoesthesia in a SI pattern on the left. There was definite plantar flexion weakness on the left and he walked with a limp. Straight leg raising was negative on the right but positive on the left causing both lower back and leg discomfort radiating to the foot. Assessment: Lumbosacral disc herniation at L5-S1 on the left with appropriate S1 radiculopathy. Significant disc pathology at the L4-5 level. Recommendations: TLIF at the L4-5 and lumbosacral disc spaces with simultaneous excision of the disc herniation at the L5-S1 level. The claimant was also instructed to discontinue smoking from that point forward to justify proceeding with the surgery he requires.

10-09-13: Pre-Surgical Psychological Evaluation. asked that the claimant's psychological status for surgical intervention be evaluated. BDI-II score was 10, indicating mild depression. BAI was 14, reflecting mild anxiety. FABQ showed significant fear avoidance of work (FABQ-W=42) as well as significant fear avoidance of physical activity in general (FABQ-PA=22). Recommendations: The claimant did not appear to present with any psychosocial stressors; (major, uncontrolled severe depression and anxiety, active suicidal ideation, serious alcohol and drug addiction or severe cognitive deficits) that would exclude him from undergoing a surgical procedure. "Although is psychologically cleared for surgery, his surgeon has asked him to quit smoking prior to the injury and to continue his abstinence from smoking throughout the postsurgical treatment. As such has indicated apprehensions about quitting his smoking habit. He has asked for help to accomplish this task. Thus it is recommended that be immediately authorized for 4 session of IPT which will focus on smoking cessation prior to the surgery".

10-12-13: Follow-up. Tobacco use was reported as Cigarettes < 1 PPD. Medications prescribed included: cyclobenzaprine, Cymbalta, naproxen, and tramadol. Plan: Continue with surgeon and counseling.

10-17-13: UR performed. Rationale for Denial: Based on the clinical information provided, the request for individual psychotherapy 1 x a week x 4 weeks is not recommended as medically necessary. Per telephonic consultation, the patient has been recommended for individual psychotherapy to assist with the patient's apprehension regarding smoking cessation. There is no indication that the patient has tried lower levels of care to include a trial of Chantix.

11-04-13: Reconsideration: Behavioral Health Individual Psychotherapy Preauthorization Request. It was argued that the surgeon recommended the smoking cessation counseling and not Chantix and that it made sense to do smoking cessation counseling to help him quit smoking to reduce the risk of

complication he may have during surgery and/or recovery. It was reported the claimant had smoked one pack a day for the past 15 years. also presented the argument that smoking cessation is medically necessary as it is listed as one of the Risk Factors for Fusion in the ODG. She also noted Criteria #6 for Patient Selection Criteria for Lumbar Spinal Fusion states: "(6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing." Smoking Cessation Goals were listed as: 1. Provide Psycho-educational information on the effects of Nicotine on medical conditions and surgical recovery. 2. Remain nicotine-free for 7 days a week for a total of 6 weeks. 3. The patient will practice deep breathing techniques upon triggers and during cravings. 4. The patient will chose healthy nutritional snacks and meals. 5. The patient will use positive self-statements when stress levels increase in order to empower his new life-style. 6. The patient will develop a structure and a new routine for daily activities which support his health life-style. 7. Establish relapse prevention plan of action specific to the patient.

11-11-13: UR performed. Rationale for Denial: Based on review of the clinical documentation submitted as well as current evidence based guidelines, this reviewer would not recommend individual psychotherapy for 4 sessions. Per notes, this has been recommended in order to facilitate smoking cessation. There is no indication from the clinical documentation that the patient has failed other methods of smoking cessation to include the use of medications. As the clinical documentation does not establish difficulty with smoking cessation or failure of medications, this reviewer would not recommend certification for the requested individual psychotherapy at this point in time. I spoke with on 11/08/13 at 4:45 pm EST and the case was discussed. Per our discussion, the patient has not tried any of the usual over-the-counter or prescription medications to cease smoking. As such, the determination remains unchanged.

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

The previous adverse determinations are upheld. I agree with the prior Reviewers that the request for individual therapy once a week for four weeks is not medically necessary because the documentation provided did not indicate that the claimant has tried other lower level methods of smoking cessation, such as over-the-counter methods or medication. There was no documentation that the claimant has had difficulty with smoking cessation or failure of other methods. The request for Individual Psychotherapy 1 x a week x 4 weeks is found to be not medically necessary.

PER ODG:

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) 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. (Mohr, 2012) Maintenance cognitive-behavioral therapy (CBT) to prevent recurrent depression is most effective in patients at highest risk for relapse, defined as those with 5 or more previous depressive episodes. For individuals at more moderate risk for recurrence (fewer than 5 prior episodes), structured patient psychoeducation may be equally effective. High-risk patients in particular may benefit from specific elements of maintenance CBT by reducing cognitive vulnerability factors for recurrent depression, such as ruminating, negative attributions and memories, and dysfunctional beliefs, or by maintaining positive emotions when experiencing stress. (Stangier, 2013) See also [Bibliotherapy](#). Psychotherapy visits are generally separate from physical therapy visits.

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)

Cognitive therapy for general stress

Recommended. Stress management that includes cognitive therapy has the potential to prevent depression and improve psychological and physiological symptoms. As with all therapies, an initial trial may be warranted, with continuation only while results are positive. (Mino, 2006) (Granath, 2006) (Siversten, 2006)

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)**