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Notice of Independent Review Decision

[Date notice sent to all parties]:

03/11/2013 and 03/21/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: reconsideration of individual psychotherapy x 6

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

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a xx year old female whose date of injury is xxxxx. The earliest record submitted for review is an initial behavioral medicine assessment performed on 01/07/13. The mechanism of injury is described as walking down stairs at work from the second floor and the next thing she knows she is waking up with her head in the lap of a man she barely even knew after sustaining a loss of consciousness for an unknown period of time. A CT scan reportedly revealed a 4 mm thick acute subdural hematoma. Follow up CT scan dated 12/08/08 was noted to show that the hematoma was resolving and becoming thinner. The patient was seen for headaches, difficulties thinking and concentrating and problems with short term memory. Medications are listed as Glipizide and OTC pain meds as needed. The patient describes pain as throbbing in her head. She endorses sleep maintenance insomnia with multiple awakenings per night and notes that sometimes she is unable to fall back asleep again. Her memory for both recent and remote events was impaired. Beck Depression Inventory score is 38 and Beck Anxiety Inventory score is 26. Diagnoses are rule out cognitive disorder nos, major depressive disorder, single episode, severe without psychotic features, and anxiety disorder nos. The patient was recommended to undergo a course of individual psychotherapy.

Initial request for individual psychotherapy 1 x 6 was non-certified on 01/29/13 noting that the patient has significant depression and anxiety; however, the patient has never been placed on psychotropic medications. Current evidence based guidelines note that the gold standard of treatment is a combination of individual psychotherapy and medication management. There is no confirmation through validity testing that the patient's reported symptoms are accurate. Reconsideration dated 02/06/13 indicates that the patient will be referred for neurology re-evaluation and psychiatric evaluation by Dr.. The denial was upheld on appeal dated 02/13/13 noting that the mental health evaluation of 01/07/13 finds impressions of rule out cognitive disorder; major depressive disorder, single episode, severe without psychotic features; and anxiety disorder nos. The cognitive screenings done (MMSE, NBC) are inadequate; and the neuropsychological evaluation is not yet complete. It is proposed to treat the patient's 'depression and anxiety' with psychotherapy, but the etiology is still unclear. A coherent treatment plan cannot be promulgated until the testing is completed.

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

Given the current clinical data, the request for individual psychotherapy 1 x 6 CPT 90834 is not recommended as medically necessary. As noted by the previous reviewer, the patient is not currently taking psychotropic medications, despite diagnoses of major depressive disorder and anxiety disorder. Reconsideration report dated 02/06/13 states that the patient will be referred for neurology re-evaluation and psychiatric evaluation; however, it is unclear if these evaluations have been performed, and no reports were submitted for review. Therefore, the request for individual psychotherapy is not considered medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR

OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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, 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](#))

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)

