

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** March 17, 2015

**IRO CASE #:**

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

Individual Psychotherapy 1x4 weeks 90837

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

The reviewer is certified by the American Board of Psychiatry and Neurology 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)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who injured his back when he tried to pick up and move a x while working on xx/xx/xx.

03/17/14: The claimant was evaluated. He reported feelings of depression, anxiety, or emotional disorders as a result of his injury. He had been employed. His daily activities included light fixture and plug installation and pulling electrical wires. He was working light duty in the warehouse at the time of this exam. Notes indicate that he attended physical therapy and epidural steroid injections. It was noted that he reached maximum medical improvement on 03/15/13, and he had 0% whole person impairment. Return to work was 03/15/13. He performed at a physical demand level of indeterminate/sedentary.

01/29/15: The claimant was evaluated. FABQ-W 41, FABQ-Physical Activity 22. BDI-II 25. BAI 37. VAS of patient symptoms ratings scale: Pain 7, irritability 4, frustration 4, muscle tension 5, anxiety 5, depression 6, sleep problems 6. Average sleep hours slept: 6 fragmented. He tested at 20 pounds PDI on his FCE. His job related PDL was 50-100 pounds. He had not completed a functional restoration program to address his lifting and carrying capacity. His current medications included tramadol 50 mg p.r.n. On mental status exam, his psychomotor activity presented with tension and restlessness. He noted he frequently felt tense and had a quick temper. His mood was anxious. His affect was constricted. He did display cognitive distortions to include mental filter. DIAGNOSIS: Major depressive disorder, single episode, moderate, with anxious distress. Somatic symptoms disorder with predominant pain, persistent, severe. TREATMENT RECOMMENDATION/PLAN: We concur with Galbraith's recommendation that the patient participate in individual psychotherapy as continues to struggle with pain and functional problems that pose difficulty to performance of routine demands of living and occupational functioning. TREATMENT GOALS FOR INDIVIDUAL PSYCHOTHERAPY: By the end of treatment, the patient will report employment of CBT techniques at least once a day with the result of improvements in mood and decreased symptoms of depression; patient will report decreased depressive symptoms, reducing BDI score from 25 (moderate) to 19 mild lower. Patient will report decreased anxious symptoms, reducing BAI score of 37 severe to 25 moderate or lower. Improve sleep. It is recommended that be approved for 4 sessions of individual psychotherapy in order to increase his physical and functional tolerances and to facilitate a safe and successful return to work.

01/30/15: UR. RATIONALE: Based on the clinical information provided, the request for individual psychotherapy 1 x 4 weeks 90837 is not recommended as medically necessary. Per designated doctor evaluation dated 03/17/14, the patient has 6 out of 8 positive Waddell's tests which is significant for symptom magnification. The recent assessment submitted for review does not contain any validity testing to assess the validity of the patient's subjective complaints. The patient is not currently taking any psychotropic medications despite a diagnosis of major depressive disorder. Therefore, medical necessity is not established in accordance with current evidence based guidelines. Peer to peer was not successful.

02/11/15: UR. RATIONALE: As per previous reviewer's comments, despite a diagnosis of major depression, the patient is not on any corresponding antidepressant medication. He is felt to have reached maximal medical improvement. His anxiety and depression scores are not so elevated as to suggest any benefit from the requested services. Peer to Peer was successful.

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

The previous adverse decisions are upheld. Denial upheld. The patient has reached maximal medical improvement. His anxiety and depression scores are not elevated to suggest he would benefit from the requested services. Therefore,

the request for Individual Psychotherapy 1x4 weeks 90837 is not medically necessary.

ODG:

<p>Psychological treatment</p>	<p>Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient’s pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following “stepped-care” approach to pain management that involves psychological intervention has been suggested:</p> <p><u>Step 1:</u> Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention.</p> <p><u>Step 2:</u> Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.</p> <p><u>Step 3:</u> Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See <a href="#">Behavioral interventions</a> (CBT). See also <a href="#">Multi-disciplinary pain programs</a>. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005) See also <a href="#">Psychosocial adjunctive methods</a> in the Mental Illness &amp; Stress Chapter. Several recent reviews support the assertion of efficacy of cognitive-behavioural therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). (Kröner-Herwig, 2009) See the <a href="#">Mental Chapter</a> for detailed information and references.</p> <p><b>ODG Psychotherapy Guidelines:</b></p> <ul style="list-style-type: none"> <li>- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made.</li> </ul> <p>(The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)</p> <ul style="list-style-type: none"> <li>- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.</li> </ul>
<p>Cognitive therapy for depression</p>	<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</p>

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](#)) Studies show that a 4 to 6 session trial should be sufficient to provide evidence of symptom improvement, but functioning and quality of life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. ([Crits-Christoph, 2001](#)) See [Number of psychotherapy sessions](#) for more information. See also [Bibliotherapy](#); [Computer-assisted cognitive therapy](#). Psychotherapy visits are generally separate from physical therapy visits.

***Subclinical depression:*** Psychotherapy may be effective in treating subclinical depression and may prevent progression to major depressive disorder (MDD), according to a meta-analysis. There has been recent controversy regarding the efficacy of psychotherapy in treating subclinical depression, and antidepressants and benzodiazepines are no better than placebo for treating this condition. The most common form of psychotherapy used was cognitive-behavioral therapy. Results showed that undergoing psychotherapy

	<p>significantly reduced the incidence of MDD at the 6-month follow-up, with a relative risk (RR) of 0.61 vs the control groups. (<a href="#">Cuijpers, 2014</a>)</p> <p><b>ODG Psychotherapy Guidelines:</b></p> <ul style="list-style-type: none"> <li>- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made.</li> </ul> <p>(The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)</p> <ul style="list-style-type: none"> <li>- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.</li> </ul>
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**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)