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Notice of Independent Review Decision

Date notice sent to all parties:

December 30, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Individual psychotherapy 6 units

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

Licensed Psychologist

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. CT of the head dated 07/19/13 is reported to be unremarkable. She attended 12 sessions of occupational therapy in September 2013. She stated after the injury she started having headaches. Current medications are Armour, Evista and Adderall. The patient endorses both initial and sleep maintenance insomnia. Her mood was anxious and her affect was constricted. BDI is 39 and BAI is 34. FABQ-W is 39 and FABQ-PA is 24. Diagnoses are unspecified neurocognitive disorder; somatic symptom disorder with predominant pain, persistent; major depressive disorder, single episode, severe, with anxious distress, severe; rule out major neurocognitive disorder due to traumatic brain injury.

Initial request for individual psychotherapy 6 units was non-certified on 11/13/14 noting that the records available for review would appear to indicate a concern with respect to compliance with appointments in the past, and additionally, specifics are not provided with respect what types of lower levels of care have been provided. Reconsideration request dated 12/01/14 indicates that the patient has not had problems with compliance issues and treatment has included medical care from dentists, ophthalmologists, medical doctors and 12 visits of occupational therapy. She is currently working part time. The denial was upheld on appeal dated 12/08/14 noting that the patient has not yet been afforded any pharmacological management. In light of her elevated Beck anxiety and depression scores, antidepressant therapy might well be the first line of treatment in a patient this ill. Then the determination can be made as to the utility of psychotherapy.

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 6 units is not recommended as medically necessary. There is no indication that the patient has been evaluated for psychotropic medication management despite a diagnosis of major depressive disorder. The Official Disability Guidelines note that the gold standard of treatment is a combination of medication management and Individual psychotherapy. Diagnosis are unspecified neurocognitive disorder; somatic symptom disorder with predominant pain, persistent; major depressive disorder, single episode, severe, with anxious distress, severe; rule out major neurocognitive disorder due to traumatic brain injury; however, there is no indication that major neurocognitive disorder has been ruled out at this time. Given the current clinical data, the requested individual psychotherapy is not considered medically necessary in accordance with the Official Disability Guidelines.

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

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) 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 significantly reduced the incidence of MDD at the 6-month follow-up, with a relative risk (RR) of 0.61 vs the control groups. (Cuijpers, 2014)

ODG Psychotherapy Guidelines:

- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made.

(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.)

- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.