

## IRO REVIEWER REPORT TEMPLATE -WC

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### IMED, INC.

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#### Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**01/06/2015**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Individual Psychotherapy 1X4 weeks.

**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 male whose date of injury is xx/xx/xx. Per initial behavioral medicine consultation dated 11/20/14, the patient felt a pain and pull in his low back. Treatment to date includes physical therapy x 12 visits, lumbar rhizotomy on 08/01/13 and 05/29/14, x-rays, MRIs, EMG/NCV, and TENS unit. The patient was referred for behavioral medicine consultation to assess his potential suitability for individual psychotherapy or a comprehensive functional restoration program. Current medications are listed as Abilify, Byetta, glimepiride, hydrocodone-ibuprofen, Losartan potassium, Nexium, Nortriptyline and OxyContin. In 2006, with the death of his son from cancer, he attempted suicide and has been under the care of a psychiatrist and on medication. Mood was dysthymic and affect was

constricted. BDI is 23 and BAI is 10. FABQ-W is 42 and FABQ-PA is 22. Diagnoses are somatic symptom disorder with predominant pain, and major depressive disorder, single episode, severe without psychotic features.

Initial request for individual psychotherapy 1 x 4 weeks was non-certified on 12/03/14 noting that the claimant has already been afforded a course of individual psychotherapy sessions in 2013. There is no documentation of that treatment or the response to that treatment. It is unclear why the same treatment would be repeated at this time. The denial was upheld on appeal on 12/11/14 noting that the evaluation does not establish a basis for psychological intervention. The utilized psychometric instruments are inadequate/inappropriate to elucidate the pain problem, explicate psychological dysfunction or inform differential diagnosis in this case; there is no analysis of medication usage; there is no substantive behavior analysis to provide relevant clinical/diagnostic information and the report does not provide a cogent explanation for the identified complaints and dysfunction.

**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 1 x 4 weeks is not recommended as medically necessary, and the two previous denials are upheld. The patient sustained injuries in xx/xxxx. There is an indication that the patient has received prior individual psychotherapy related to this injury; however, there is no information provided regarding this treatment. The number of individual psychotherapy sessions completed to date and the patient's response thereto are not documented to establish efficacy of treatment and support additional sessions, in accordance with the Official Disability Guidelines. Additionally, there is no indication that the patient has undergone psychometric testing with validity measures to assess the validity of the patient's subjective complaints. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines.

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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**

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.