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Notice of Independent Review Decision

DATE: April 7, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Individual Psychotherapy 1 x 4 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/Psychiatry 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.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured his neck, left and right shoulder, upper arms, elbows, and wrist when he fell at work on xx/xx/xx.

02/19/13: A record review found that the most medically probable work-compensable diagnosis was nondisplaced left radial head fracture, nondisplaced right radial head fracture, right wrist TFCC tear, right wrist dorsal capsular sprain, and left wrist dorsal capsular sprain. felt that the shoulder and cervical complaints were unrelated to the claim. He felt that more than enough treatment had been rendered over a period of time then eclipsing nearly 9 months for his compensable diagnoses and that the need for current or future treatment did not appear to be warranted at that time.

01/28/15: A Decision and Order from TDI Division of Worker's Compensation concluded that the compensable injury of xx/xx/xx extended to and included wrist sprain/strains and did not extend to or include cervical disc herniations; cervical IVD syndrome; bilateral traumatic carpal tunnel syndrome; cervical sprain/strain/ left wrist TFCC tear; cervical disc hyperreflexia and possible cervical myelopathy;

bilateral rotator cuff tears; ulnar neuropathy; cervical radiculopathy at C6, C7, and C8; 2 mm posterocentral disc protrusion at T11-T12; bilateral shoulder tendinosis of the supraspinatus; bilateral shoulder bursitis; bilateral shoulder sprain/strains; or bilateral shoulder impingement. Claimant reached maximum medical improvement on June 13, 2014 and impairment rating was 1%.

02/10/15: The claimant was evaluated for behavioral medicine consultation to assess emotional status and to determine the relationship to the work accident. His current medications included Cymbalta 30 mg capsule delayed release particles oral b.i.d., gabapentin 600 mg t.i.d., ibuprofen 800 mg, and methocarbamol powder. He had an unremarkable medical history. It was noted that he attended counseling in the past but he had no history of psychological difficulty requiring psychotropic medications and/or hospitalization prior to his injury of 06/08/12. At this visit, he self-rated his pain as 10/10. He rated various pain levels as follows: with medication 10, without medication 10, at its worst 10, and his average daily pain as 9/10. He described the pain as burning through base of neck, shoulders, and upper back; pins and needles at the base of neck and upper back; aching in both elbows; and stabbing pain in both wrists. When asked to quantify the level of interference his pain had on his recreational, social, and familial activities, he rated these all as 10/10; for pain interference with normal activities as 8/10; and change in ability to work 10/10. He reported difficulty with acts of daily living. He described negative changes in his relationships. He described changes in self-perception such as losing confidence in himself, feeling useless/helpless/like a burden, and feeling disappointed with himself. He reported difficulty falling asleep due to pain and early awakening. He reported sleeping 3-4 fragmented hours per night. He reported a 30-pound weight gain due to loss of function since the injury. He rated his overall functioning in life prior to the injury at 100% but was unable to rate his current level of functioning. He believed that his function was drastically diminished but was indecisive in quantifying the loss of function. On mental status exam, he was oriented. His attention and concentration were easily broken. His psychomotor activity was restless with frequent closing of eyes and tough face. His speech was normal. His mood was dysthymic. His affect was constricted. He displayed cognitive distortions to include personalization, minimization, and mental filter. His memory for both recent and remote events was slightly impaired. His thought process was circumstantial. He did not hallucinate or appear delusional. Judgement and impulse control were deemed to be fair. His insight was deemed poor. He did not present with any current risk factors. Beck Depression Inventory-II (BDI-II) and Beck Anxiety Inventory (BAI): Score of 7 on BDI-II, indicating minimal depression. BAI score 6, reflecting minimal anxiety. FABQ-W of 42, showing significant fear avoidance of work. FABQ-PA of 42, indicating significant fear avoidance of physical activity in general. He endorsed 8/9 DSM-5 symptoms for Major Depressive Episode. DIAGNOSIS: Somatic Symptom Disorder with predominant pain, persistent, severe. Major Depressive Disorder, single episode, moderate, with anxious distress. TREATMENT GOALS FOR IDENTIFIED DEFICIT AREAS WITH COGNITIVE BEHAVIORAL INTERVENTION: Psychotropic medication monitoring is advised. Cognitive Behavioral Therapy. Low level of individual psychotherapy at least 1 x per week for a minimum of 6 weeks. TREATMENT

GOALS FOR INDIVIDUAL PSYCHOTHERAPY: Improvements in mood and decreased symptoms of depression, decreased symptoms of anxiety, and improved sleep.

02/20/15: UR. CONCLUSION: This claimant is currently 2 years, 8 months post soft tissue injury. On a recent interview/evaluation, the claimant scored very minimal scores for anxiety and depression on the BAI and BDI-II. There is no record of any medications being used for psych issues prior. The medical records indicate the claimant has had counseling before, but there is no evidence of prior treatment efficacy, which is required to support continued care or treatments. This claimant does not have significant psych issues to support the current request. The current request is not consistent with the evidence based guidelines, ODG.

03/09/15: A reconsideration request from notes: He did display cognitive distortions to include minimization. The clinician felt his insight was poor. A brief course of individual psychotherapeutic intervention using CBT approaches and basic self-management strategies coupled with autogenic exercises to facilitate a healthy adjustment and improve coping with their overall condition. This should assist the patient in developing tools and skills for the management of their injury-related disturbances in mood and sleep. He did endorse high pain ratings and fear avoidance of physical activity at work. His attention to pain and change of lifestyle has affected his life. MEDICAL NECESSITY: The Texas Labor Code, on Entitlement to Medical Benefits, states that: “An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that: Cures or relieves the effects naturally resulting from the compensable injury; or promotes recovery; or enhances the ability of the employee to return to work or retain employment.”

03/13/15: UR. Peer-to-Peer was conducted on 03/12/1 via phone. CONCLUSION: points out that one cannot simply go by the patient’s very low depression and anxiety scores here as he endorses 5 of 9 symptoms consistent with major depression. Conversely, however, he reports that the patient has had a very good response to the antidepressant Cymbalta. These two statements would appear to be in contradistinction to each other. If in fact the patient’s subjective anxiety and depression scores are low, and his response to pharmacological support is good, the necessity for augmenting therapy is totally unclear. The request cannot be approved.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse decisions are upheld. This examiner reviewed the decision from the TDI Division of Worker’s Compensation that concluded that the compensable injury of June 08, 2012 extended to and included wrist sprain/strains. Now, two years later, the claimant has 10/10 depressive symptoms yet the Beck Depressive inventory was a 7. These types of results show a glaring inconsistency in what he is claiming and what he declared in the

self-report Beck Depression Inventory. Therefore, the request for Individual Psychotherapy 1 x 4 weeks 90837 is not medically necessary, and this examiner upholds the previous denial.

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) 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; Mind/body interventions (for stress relief). 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.

Psychotherapy for MDD (major depressive disorder)	Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. (American Psychiatric Association, 2006) See also Cognitive therapy for additional information and references, including specific **ODG Psychotherapy Guidelines** (number and timing of visits). *Patient selection*. Standards call for psychotherapy to be given special consideration *if* the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans which did not involve psychotherapy. *Types of psychotherapy*. The American Psychiatric Association has published the following considerations regarding the various types of psychotherapy for MDD: - Cognitive behavioral psychotherapy is preferable to other forms of psychotherapy, because of a richer base of outcome studies to support its use, and because its structured and tangible nature provides a means of monitoring compliance and progress. - In contrast, psychodynamic psychotherapy is not recommended because

	it has specifically been identified as lacking scientific support, and is severely vulnerable to abuse because it can involve a lack of structure. (American Psychiatric Association, 2006) Placebos about did as well as antidepressants or cognitive therapy in this RCT on MDD treatment, although there were hints that the effects varied by gender and race. In the antidepressant group, 31% responded (as judged by improvements on the Hamilton Rating Scale for Depression). The same was true of about 28% of patients in the psychoanalysis-therapy group, and 24% in the placebo group. The researchers found that African-American men tended to improve more quickly with talk therapy than with medication or placebo. In contrast, white men fared best on placebo, while black women showed no differences in their responses to the three treatments. Only white women showed the expected pattern: a quicker response to both medication and talk therapy than to the placebo. (Barber, 2012)

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)**