

P-IRO Inc.

An Independent Review Organization
1507 Frontier Dr.
Arlington, TX 76012
Phone: 817-235-1979
Fax: 866-328-3894

DATE OF REVIEW: APRIL 19, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 additional individual psychotherapy sessions, 2 X week X 5 weeks.

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

Licensed Master Social Worker (LMSW), licensed in Texas
5 years experience as social worker in psychiatric hospital, with individual (one on one) patients, group therapy, family therapy, psychiatric intensive care unit, regular adult psychiatric unit, children and adolescents, and chemical dependency patients.

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)

10 additional individual psychotherapy sessions, 2 X week X 5 weeks is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of case assignment (4/10/07); Medical Records from Systems; Medical records from URA.

The records include, in brief chronological description, the following:

- Description of critical incident, occurring
- Progress Notes from MC, LPC, Psychological & Neurobehavioral Services, dated from 1/7/03 thru 3/4/03. (These records include claimant's application/physician's statement for temporary disability for 6-12 months, dated 1/7/03).
- Letter from Disability Determination Officer, dated 8/3/03
- Release to return to work, dated 8/31/04, from Dr.
- Report of claimant's visit to Emergency Center, dated 12/18/04.
- Letter from LPC, dated 12/20/04, recommending light duty or time off for the next two weeks.
- Letter from M.D., P.A. containing peer review information, dated 8/2/05
- Examination findings of D.O., dated 9/27/06
- Examination findings of M.D., dated 10/3/06
- Evaluation by Healthcare Services, dated 10/9/06.
- Request to for Pre-cert for 6 sessions of counseling, dated 10/19/06.
- Letter from Healthcare Services, dated 11/14/06 requesting an appeal regarding denial of 6 sessions.
- Letter from dated 11/17/06, disputing entitlement of medical care.
- Peer review letter from Psychologist dated 11/20/06.
- "Mental and Behavioral Health Consultation & Progress Notes" from Healthcare Systems, dating from 11/24/06 thru 1/5/07, including a Healthcare Systems RE-Evaluation, dated 12/28/06.
- Request for an appeal for 10 additional sessions from Healthcare Services, dated 1/31/07.
- Request for Medical Dispute Resolution for Work Comp to P-IRO, Inc., dated 4/9/07.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was accosted outside her place of employment by two armed, masked males who pointed guns at her demanding money. This apparently went on for some time although she kept insisting that she did not have money nor access to money. They eventually fled, and she was not physically injured. Patient began exhibiting symptoms of Acute Stress Disorder, i.e. isolating, fearful, unable to leave home without someone accompanying her, feeling that the event was controlling her life, hypervigilant, anxious, disturbed sleep, panic. She attended psychotherapy sessions at the Psychological & Neurobehavioral Services, where she underwent several treatment modalities including hypnosis, Cognitive Behavioral Therapy, EMDR, Relaxation techniques, and medication therapy (Zoloft). (She applied for temporary disability on.) Based on the eight progress notes that this reviewer received from this particular therapist, patient seemed to make some progress, but continued to be anxious and fearful. The last progress note is dated 3/4/03, with a note that patient is to return in 2 weeks to continue cognitive behavioral therapy and hypnosis, however, there is lack of continued documentation of psychotherapy.

The next activity documented is an apparent visit to a disability examiner, Dr., who documented morbid obesity, gout, and post partum depression. Past surgical history included 1) tubal ligation 2) ovarian cystectomy 3) status post open reduction and internal fixation blowout fracture of orbit for tonsillectomy. The disability examiner, Dr. points out that the patient "clearly has issues" and notes that patient "has not reached maximum medical improvement." but that he did not have sufficient documentation to review her case at that time. He recommended that patient undergo psychometric testing and evaluation by one Dr. to determine a baseline for patient so that re-evaluation could determine a stable clinical condition, improvement or deterioration. There is no mention of further re-evaluation by Dr., or Dr. in the records received by this reviewer.

The next activity in the patient's clinical history occurred on 8/31/04, at which time she was released to return to work effective immediately, by Dr. PhD.

On Saturday, 12/18/04, the patient visited an Emergency Center. The documentation from this ER visit indicates that patient's presenting problems were due to anxiety and emotional distress. She was released with an appointment to see her primary care physician on 12/27/04. On 12/20/04, patient was seen by in her office. Ms. provided patient with a note to her employer explaining that patient was suffering from significant PTSD, with symptoms worsening of late, and recommended that patient either be given light duty or time off for the next two weeks. Ms. states "I believe that [patient] has had an excellent work record in the past and our plan is to restore a valuable individual and employee."

Dr. wrote a peer review on 8/2/05, which will be referred to later in this report.

The next set of clinical documentations provided to this reviewer begin with an examination on 9/27/06, by D. O., who assessed patient with PTSD, and referred her to medical Dr. With both doctors, patient described the initial critical incident as the presenting problem, with resulting anxiety and inability to function. She was evaluated by, at Healthcare Systems on 10/9/06, at which time he diagnosed PTSD

(Axis I) and Problems with primary support group, problems related to social environment, occupational problems, economic problems (Axis IV). Regarding Axis V, current GAF was 50, highest in past year was also 50. Prior to injury was 79. Six sessions of Individual Counseling and six sessions of biofeedback were recommended. These were denied, but appealed and approved.

Beginning 11/24/06, patient has been in psychotherapy at the Healthcare Systems. Her dates of attendance have been 11/24/06, 12/8/06, 12/15/06, 12/29/06, and 1/5/07. Goals of treatment have been to decrease PTSD symptoms. Therapists believe that patient has begun to respond to treatment and apply strategies to cope with her feelings and begin to normalize a routine for her living and lifestyle. Ten additional sessions have been requested, and are being disputed by the insurance carrier. Carrier claims that PTSD and conditions related to it should have been resolved by 3/9/03, and that her symptoms cannot be separated from ordinary life stressors.

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

The claimant/patient was “injured” outside her place of employment when, as she was leaving work, she was accosted or “mugged” by two masked, armed men. The men repeatedly demanded money from her, and pointed their guns at her chest. She had to convince them that she did not have money nor did she have access to money. The assailants ultimately fled, and were never caught. The patient was not physically injured. She stated that she began thinking of her family and the holiday season during the robbery. Afterward, she began experiencing acute reaction to stress, i.e. nervousness, insomnia, panic attacks, hypervigilance, decreased appetite, fear of being alone. She attempted to return to work on 12/13/02, but needed to be accompanied by her husband the entire time.

The patient began attending psychotherapy sessions on 1/7/03 with, LPC. She attended six sessions, ending on 3/4/03. Treatment modalities included hypnosis, cognitive behavioral therapy, EMDR, relaxation and breathing techniques. She applied for temporary disability on 1/14/03. The patient was released to return to work on 8/31/04, with the recommendation that she not return to the store where she was robbed.

The patient went to an Emergency Center on 12/18/04, where she was informed that her presenting problem is from anxiety and emotional distress. She was referred to her PCP and treated with benzodiazepine. On 12/20/04, LPC, again saw the patient. Ms. wrote a letter to patient’s employer recommending either light duty or time off work, stating that she was suffering from significant PTSD. In her letter, Ms. stated “I believe that [patient] has had an excellent work record in the past and our plan is to restore a valuable individual and employee.”

On 9/27/06, and on 10/03/06, the patient was evaluated by, D.O., and, M.D., both from Healthcare Systems. The patient again described her attack, and the resulting trauma symptoms. noted that she was “extremely hyperactive,” “dysfunctional,” and “morbidly obese.” He also indicated a family history of bipolar disorder, although his assessment was Posttraumatic stress syndrome, as was Dr.. She was referred to the Healthcare Systems for a psychological evaluation. LPC on 10/9/06, performed the psychological evaluation. Mr.’s DSM IV Diagnostic Impressions

Axis I 309.81 Post Traumatic Stress Disorder

Axis II V71.09 No Diagnosis

Axis III V71.09 No Diagnosis

Axis IV Problems with primary support group, problems with social environment, occupational problems, economic problems.

Axis V GAF (current 50) Highest past year (50) Prior to injury (79)

Six sessions of psychotherapy and biofeedback was recommended.

It was at this point that patient’s insurance carrier began refusing to pay benefits, although six sessions were ultimately allowed. A peer review letter had been submitted by Dr. M. D., P. A., on 8/2/05, in which he suggested that the patient’s PTSD was “reasonably resolved by March 9, 2003.” This was the date

of the patient's last psychotherapy appointment with her original therapist. Dr. stated that "documentation did not support the patient's currently claimed symptoms are causally related to her compensable injury. There is reasonable suspicion that currently claimed symptoms are related to ordinary life stressors and possibly exaggerated." Dr. pointed out that Ms. s' documentation did not include "an in-depth psychological exploration for personality disorder or secondary gain influencing exaggerated symptom behavior. The likelihood is substantial that ongoing therapy is reinforcing a pattern of maladaptive behavior that in the long term cannot be to [patient's] benefit." Dr. also states "Ms.'s notes reflect a pattern of 'forward then backward' progress....typical of what used to be labeled compensation neurosis and which requires in-depth psychological probing of personality factors...Without minimizing the initial effects of [patient's] traumatic incident, she was not physically manhandled. Her perpetrators fled." Dr. recommends an in-depth psychiatric evaluation to substantiate a peer review impression of exaggerated symptom behavior enmeshed with ordinary life stressors accounting for current symptoms. He states that regarding patient's compensable injury, no further treatment is necessary. "Should in-depth psychiatric evaluation demonstrate areas of personality dysfunction, [patient] should be offered non-injury related referral for counseling."

Another peer review letter was submitted on 11/20/06, by, PhD. Dr. summarizes the clinical history of the patient, and states, "I basically concur with his opinions." Dr. states, "There is a reasonable suspicion that currently claimed symptoms are related to ordinary life stressors and possibly exaggerated symptom behavior." He says, "Dr. raises the concern that the length and frequency of symptoms approaching three years posttraumatic event was inappropriate." Dr. notes that patient was seen at the Clinic on 9/27/06 and 10/3/06....she had not been taking medications for two years....has not worked since. Dr. states that in the 10/3/06 visit, the patient "continues to complain of symptomatology that in my opinion is grossly exaggerated and not consistent with the nature of the events. We are talking now almost four years since the incident and it appears that she is totally incapacitated to the point that the claimant is 'unable to participate in ADL's much less go to work.'" Dr. also reflects that the patient's presentation should be limited to an acute posttraumatic stress disorder, which most likely resolved by 3/9/03, when she apparently stopped seeing Dr.. Dr. thinks that according to the records he has reviewed, she has had a response to this event that is out of proportion with what you would expect. "This raises concerns of symptom magnification and secondary gain factors." He also recommends detailed psychological assessment, including psychometric testing.

After having been evaluated by D. O. on 9/27/06, by Dr. on 10/3/06, and by LPC, on 10/9/06, the patient has been treated at the Healthcare Systems on six occasions, beginning 11/24/06 through 1/5/07. In Mr.'s evaluation, he noted psychological symptoms of sleep disturbance, fatigue, depression, loss of interest, changes in weight, feelings of worthlessness, guilt, loss of concentration, irritability, muscle tension, panic through palpitations, sweating, trembling, breathing, feelings of choking, chest pains, dizziness, feelings of loss and control,

signs of PTSD through intrusive thoughts, recurring dreams, psychologically re-experiencing the event, avoidance of thoughts and conversations about the injury, avoiding people, places, activities, poor recall of robbery, hypervigilance, and startle response. Regarding her mental status, he found her thought process was tangential, she had flight of ideas, was incoherent, illogical. Thought content was preoccupied, obsessive, and phobic.

She has significant symptoms of anxiety and depression (Beck Inventory). She continues to experience other symptoms of PTSD such as intense fear of unknown sources, crying spells, nightmares, flashbacks, and disturbed sleep patterns. Based on progress notes of psychotherapy sessions, patient appears to be engaging in therapy through discussion of issues (such as awareness of her loss of self power, confidence, triggers for anxiety/panic/stress, etc.) and she is applying strategies to deal with these, such as setting goals, writing/journaling, completing homework, improving frequency of outside exposure (for agoraphobia), and attempting to normalize daily routines. A medical re-evaluation on 12/28/06 noted that patient was somewhat labile, judgment somewhat diminished, mood & affect incongruent at times. She was assessed as having PTSD, depression and panic disorder. Her therapists indicate that her goals for treatment are *not met*, but progress is **beginning** to indicate additional individual therapy sessions will allow her to accomplish treatment goals. It would be detrimental to the patient to cease psychotherapy now.

This reviewer agrees with the recommendation that ten additional sessions be approved for this patient. The patient did undergo fairly extensive evaluation, as Dr. and Dr. both recommended in their peer review letters. The patient appears to have made progress in treatment. It seems that she now has a more cohesive treatment team. Given changes in her medication and continued psychological support, she should continue to progress. Her therapist, LPC, notes that she has good family support, a good work history, and a strong determination to recover.

According to the National Institute of Mental Health, PTSD develops after a terrifying ordeal that involved physical harm or **the threat of physical harm**. This reviewer specifically takes issue with Dr.'s inference that the patient "was not physically manhandled...Her perpetrators fled," so maybe she should just get over this trauma more quickly.

PTSD was first brought to attention of the public in relation to war veterans, but it can result from a variety of traumatic incidents, such as **mugging**, rape, torture, and other forms of abuse, car accidents, bombings, or natural disasters. Symptoms usually begin within three months of the incident, but occasionally emerge years afterward. Some people recover within six months, while others have symptoms that last much longer. (In many ways, PTSD is like grief, in that it takes whatever time it takes to recover.) In some people, the condition becomes chronic. Simply because the patient stopped seeing Ms. "reasonably resolved" by that date, as both Dr. and Dr. would argue. There could be various reasons to speculate why the patient stopped seeing her therapist at that time,

such as financial concerns, other family issues, or an emotional shift or block. If indeed the patient is exaggerating symptoms for secondary gain factors, it is hoped that her current therapists will be able to discern this sometime during the next ten sessions of psychotherapy.

Certain kinds of medication and certain kinds of psychotherapy usually are successful in treatment of PTSD. The patient's current treatment team indicates that individual counseling sessions can promote stabilization in symptoms of depression and anxiety through cognitive behavioral techniques, supportive listening, stress management training and positive coping strategy training. The sessions will implement behavioral sleep modifications, sleep hygiene, encourage daily activity and reduce feelings of guilt, helplessness and worthlessness. The patient has acknowledged that she has been unable to work, which has affected her sense of identity and worth. Clinical research by Dennis C. Turk, PhD., University of Washington in Seattle, states that one category of patients, called "Dysfunctional" patients, have a high level of emotional distress, and feel that they have little control over their lives, and are in severe pain. The therapist has outlined a plan with treatment goals focused on the reduction of depression and anxiety, and teaching coping and stress management skills.

The reviewer concludes that the outlined treatment goals are in compliance with the Texas Labor Code (408.021) which states that an employee who sustains an injury is entitled to **all** health care reasonably required by the nature of the injury as needed. Furthermore, Rule 408.021 specifically states, "All health care must be approved or recommended by the employee's treating doctor." According to documentation, the employee's doctor recommended this course of treatment. After reviewing all the documentation, it is this reviewer's determination that ten additional psychotherapy sessions be authorized.

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)