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Notice of Independent Review Decision

DATE OF REVIEW: September 24, 2007

IRO CASE #:

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

This case was reviewed by a psychologist, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Individual psychotherapy, one times six weeks

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

REVIEW OF RECORDS

- Submitted medical records were reviewed in their entirety.
- August 16, 2007 utilization review report
- August 29, 2007 reconsideration letter from MA, LPC
- September 7, 2007 utilization review letter
- August 3, 2007 initial behavioral medicine consultation report by MA, LPC
- August 3, 2007 initial behavioral medicine consultation by LPA, LPC
- July 31, 2007 report by D.O.
- August 31, 2007 environmental intervention sheet by Ph.D.
- August 3, 2007 addendum by, LPA, LPC

CLINICAL HISTORY SUMMARY

According to the medical records, the patient sustained an industrial injury. A utilization review letter, dated August 16, 2007, states that the patient has a seven-week history of face, neck, and bilateral upper extremity and lower extremity pain complaints, secondary to reported chemical burn injuries. He has had a course of conservative care and there is no reported need for grafting. The patient is being managed with topicals and work restrictions. He has a history of post-traumatic stress disorder, etiology unknown, with symptoms not reported. A non-certification was rendered for the following reasons. W hile the August 3, 2007 evaluation includes impressions of major depressive disorder, the diagnosis was not supported. The reviewer stated that there are no notable vegetative signs and scores on the Beck Depression Inventory are not expositive of this as a disorder. The report states that there is no documentation, and no other data provided, that this problem constitutes a delay in the usual time of recovery from the antecedent injury or specific behavioral or psychological findings that suggest risk factors for delayed recovery or chronicity, thus requiring psychological or behavioral services to resolve.

A reconsideration letter, dated August 29, 2007, was submitted for review. The letter states that the patient has received

counseling for post-traumatic stress disorder and the post-traumatic stress symptoms had resolved. In addition, the letter states that a score of 22 in the moderate range (BDI-II) and a score of 47 in the severe range (BAI) does not represent a lack of evidence for major depressive disorder. The patient's mood was dysthmic and anxious, with a constricted affect on the date of the interview. He endorses both initial and sleep maintenance insomnia. He notes that he slept eight hours per night preinjury, and currently sleeps three fragmented hours per night. He reports his level of overall functioning prior to work injury is 90% and his current level of overall functioning as 40%. He states that his appetite has increased since the work injury after having a steroid injection to help decrease pain from the work injury. He noted that his weight has increased by 10 pounds. He endorsed symptoms indicative of major depressive disorder since the work injury, to include: Depressed mood, anhedonia, insomnia, or hypersomnia nearly everyday, psychomotor agitation or retardation nearly everyday, fatigue or loss of energy nearly everyday, feelings of worthlessness or guile, and diminished ability to think or concentrate. The letter states that certainly a trial of six sessions would help the gentleman to gain insight into his mood disturbance and cope better with his injury and help facilitate a return to gainful employment. Further, the plan is to work to reduce disturbances in mood and results psychosocial stressors by providing the appropriate community resource referrals. It is expected that this level of treatment will create a very positive response in his physical rehabilitation program and accelerate his recovery while simultaneously resolving psychosocial stressors and developing a plan to expedite his return to normal functioning. The letter notes that the July 31, 2007 report from the patient's physician clearly states that his treatment plan includes physical therapy.

On September 7, 2007, another utilization review letter rendered a non-certification. The report notes that guidelines recommend that a psychological evaluation should distinguish between conditions that are pre-existing or work related. Without inadequate evaluation of these factors, the appropriateness of this request could not be determined. Furthermore, the letter states that the patient is experiencing acute pain for the injury of June 20, 2007. The guidelines state that "in patients with chronic pain psychological reactions become the major contributors to impaired functioning." The letter states that this is a new injury with acute pain and the patient is actively involved the medical treatment. There is no evidence provided in the documentation that the injury related symptoms are causing a delayed recovery from this injury according to the reviewer.

An August 3, 2007 initial behavioral medicine consultation report states that the patient was referred to determine his treatment needs and for an evaluation of emotional status and subjective pain to assess the relationship to the work accident. The patient stated that he was working with chemicals and detergents in 120° hot water while wearing latex gloves, when some of the hot water splashed on his face. The hot water dripped down to his feet and the skin began feeling irritated and itchy. Present medications include Benadryl, prednisone, Amlactin, methylprednisone, Hydroxyl HCL, triamcinolone, and lorazepam.

The patient rated his level of interference of his pain with regards to recreational, social, and familial activities as 9/10. Past medical and psychiatric history was positive for psychotherapeutic services due to emotional distress and post-traumatic stress disorder, which has since been resolved. Since the injury, the patient noted changes in interpersonal relationships including increased family conflict, isolating from others, decreased participation in social activities, and feeling abandoned by his coworkers. He noted changes in self perception including a loss of confidence, feeling useless, feeling disappointed or angry with himself, feeling unattractive, and increased sensitivity to criticism and having his feelings easily hurt. He reported feelings of distress due to his decreased wages from the work injury. He notes that he cannot pay his bills and receives assistance from the Help Center with paying some of the bills. The report notes that based on information gathered, a determination was made that the work accident and the ensuing functional limitations have caused the patient's disruption and lifestyle, leading to disturbances in sleep and mood. He appears to have been functioning independently prior to the work injury of June 20, 2007. It was recommended that he be immediately referred for a psychotropic medication consultation. Also recommended was a brief course of individual psychotherapeutic intervention using CBT autogenic and progressive muscle relaxation with guided imagery/hypnotherapy to facilitate a healthy adjustment and improve his coping with his overall condition by using basic relaxation techniques.

ANALYSIS AND EXPLANATION OF DECISION

The August 3, 2007 behavioral medicine report establishes that while the patient had a history of post-traumatic stress disorder, the symptoms have resolved and the patient's current symptoms are related to the work injury of June 20, 2007. The report documents that the patient has major depressive disorder secondary to the work injury. As noted in the medical references, the Official Disability Guidelines recommend cognitive behavioral therapy for depression. The guidelines recommend a trial of six initial visits over the course of six weeks. Therefore, I recommend to overturn the determination to non-certify individual psychotherapy, one times six weeks.

The IRO's decision is consistent with the following guidelines:

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

__x__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

Official Disability Guidelines (2007): 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)
ODG Psychotherapy Guidelines:
Initial trial of 6 visits over 6 weeks
With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)

Official Disability Guidelines (2007): Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory, (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale - VAS. (Bruns, 2001) See also Psychological evaluations, SCS (spinal cord stimulators) & the Chronic Pain Chapter.