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Notice of Independent Review Decision

DATE OF REVIEW: 12/02/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: psych 1 x 6

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

Diplomate, American Board of Pain Medicine
Diplomate, American Board of Psychiatry and Neurology in Psychiatry
Diplomate, American Board of Quality Assurance and Utilization Review
American Society of Addiction Medicine
Health and Human Services Certification for Outpatient Suboxone Detoxification.

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Health, 09/22/09 thru 11/03/09
2. 10/13/09, 11/10/09
3. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee had unspecified injury xx/xx/xx and apparently individual psychotherapy is being requested for passive suicidal ideation. Beck Depression and Anxiety Inventories are 40 and 41 respectively.

An initial **Behavioral Medicine Consultation** (by a non-physician) indicated that the claimant was picking up a child weighing 10-15 pounds, and she sat down on a cushion on the floor and felt muscles in her back strain. She apparently started to be treated for

pain in her low back which was being rated at 7/10. She has nine years of formal schooling. She was diagnosed with a major depressive disorder recurrent secondary to work injury and rule out pain disorder with no diagnosis on Axis II. There are no objective measures and no apparent independent examination. Axis III diagnosis was given but no physical examination was done.

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

There was no independent examination. There is no rationale supporting how a low back strain lead to her recurrent major depressive disorder that is consistent with known epidemiology for depression. There is no physician evaluation. Medical necessity for the requested procedure cannot be established. There are no objective measures and inadequate explanation as to why personality disorder is ruled out. There is a rule out pain disorder which is not adequately explored medically. Providing non-medical psychotherapy in this context runs the risk of reinforcing pain complaints.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. ***Official Disability Guidelines*** pain section

Note: In workers' compensation cases, providers may need to shift focus from a "cure and relieve" strategy to a "functional restoration" paradigm. Too much attention may be focused on the "pain" and not enough on functional restoration and gain that encourages "coping" strategies and the desirable outcome of "working" with pain. Also consider the possibility of patients developing "Wounded Worker Syndrome," a chronic pain condition characterized by failure of an injured worker to respond to conventional healthcare measures, and prolonged disability with continued absence from the workplace. The main contributor of this condition may be the healthcare system itself, which reinforces the "sickness" role of the injured worker and provides many misguided interventions due to a lack of adequate assessment of underlying psychosocial factors. (Nemeth, 2005)

ODG Integrated Treatment/Disability Duration Guidelines

Mental Illness & Stress

Note: The Treatment Planning section outlines an ideal approach. It will often not be possible to obtain an ideal approach from the involved clinicians. Refer to the Procedure Summaries for a continually expanding and updated list of the various services that may be available, along with links to the scientific evidence.

I. Outline of treatment planning:

Initial response to presenting complaint

- A claim of mental illness will typically begin with the claimant presenting some psychological complaint to a general medical clinician.

- The general medical clinician's expertise will often be sufficient to allow him or her to make a preliminary determination that the complaint does not justify concerns that the claimant is mentally ill.

- But if the general medical clinician perceives the complaint to be potentially indicative of mental illness, he or she should respond with a recommendation that mental health consultation take place outside of the workers compensation system, because...

- o It is highly improbable that work-relatedness can be credibly established for a presentation of mental illness, and...

- o Unjustified involvement in workers compensation is associated with a relatively poor clinical outcome.

- If the general medical clinician is administratively compelled to address the psychological complaint as if it were a work-related issue, the ideal next step is for the general medical clinician to administer in-house psychological testing in order to collect objective data regarding whether the claimant's presentation is indeed consistent with mental illness.

- o Such objective data will provide a scientifically credible basis for determining whether referral for mental health evaluation is justified.

- o Such objective data will provide a scientifically credible, and individualized, basis for addressing issues of potential work-relatedness.

- If the general medical clinician who is first confronted with the psychological complaint is not prepared to administer such preliminary psychological testing, it can often be arranged through some other general medical facility (such as an occupational medicine clinic), or through a psychologist who promises to limit initial services to such testing.

Mental health evaluation

- If the preliminary steps described above produce justification for mental health evaluation, referral can be made for such.

- Such referral should typically be made to a specialist who can provide a comprehensive evaluation, such as a psychologist or psychiatrist, who will not be fettered by educational or licensure limitations.

- Ideally, the evaluation will take place outside of workers compensation, given the improbability of mental illness being work-related, and the harmful health effects of involvement in workers compensation.

- If the evaluation must take place within workers compensation (e.g., because of administrative dictates), then it **MUST** take place on an independent basis, with the mental health specialist agreeing that he or she will never take on a treating role for the claimant (professional standards in this regard are discussed below).

Diagnosis

- Mental health science is primarily categorized by diagnosis, therefore a credible diagnostic formulation is of the greatest importance for evaluation and treatment planning.

- The diagnostic process must be primarily based on full utilization of the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.
- Psychological testing can be an extremely valuable method of introducing objectivity, credibility, and comprehensiveness into the diagnostic process, IF it is used in a scientifically credible fashion.

Treatment planning

- Treatment planning should be based on the ODG Treatment procedural summary entry for the identified diagnosis.

II. Introductory discussion of claims of mental illness within workers compensation

A. The reason for this chapter's existence

From a scientific perspective, a credible argument could be made that there is no place for mental health care in workers compensation, and subsequently no need for this chapter in a workers' compensation medical treatment guideline. That argument would be based on the difficulty that is associated with any effort to establish a credible claim of work-relatedness for mental illness (as well as on additional issues which would be beyond the scope of this discussion). In order to credibly establish work-relatedness, there must first be a clearly established scientific basis for concluding that the health condition in question is generically caused by occupational exposure. There is no such basis for mental illness. Instead, mental illness is characterized by a pervasive lack of definitive causation science. The ramifications of this set of circumstances include the fact that the diagnostic system for mental illness strays from the model of all other specialty areas, in that it is not based on the etiology of the disorders. (Phillips, 2003) This abnormal approach to diagnosis has been made necessary by the simple fact that most mental illnesses do not have an identifiable cause. (Caine, 2003)

The difficulty establishing work-relatedness for mental illness raises a question in regard to why this chapter exists. The answer is: Because claims of mental illness have somehow become common in some workers compensation systems, despite the lack of scientific support for causation claims. That phenomenon has made this chapter necessary. In fact, ODG stakeholders are regularly reporting that the frequency of mental illness claims in workers compensation is increasing over time. Workers compensation payers are being compelled to pay for mental health treatment.

Therefore, there is a need to distinguish credible mental health care from non-credible mental health care.

B. A necessary limitation in the scope of this chapter

Another ramification of the lack of definitive causation science for mental illness is the difficulty that will be faced in any effort to establish necessity, appropriateness, reasonableness, etc., for treatment plans within workers compensation. For many jurisdictions, determinations of treatment necessity and appropriateness are complicated by a link to considerations of work-relatedness. Specifically, regulations often require determinations of treatment reasonableness to be focused on a relationship to occupational injury or disease (e.g., Can the proposed treatment be credibly endorsed as necessary and appropriate for an occupational injury or illness?), rather than on a simple consideration of whether the treatment is generically reasonable for the claimed condition. The lack of definitive causation science for mental illness

creates an obstacle to credibly claiming work-relatedness, and subsequently creates an obstacle to credibly claiming that mental health treatment is appropriate for an occupational injury or disease.

Therefore, this chapter must focus on generic science, rather than specifically focusing on whether mental health care will be necessary and appropriate for an occupational injury or disease. This generic approach is necessary in order to comply with the purpose of ODG Treatment, which is to provide a discussion of treatment (rather than a discussion of work-relatedness). This generic focus is also necessary because the various administrative layers of workers compensation systems often separate the issue of appropriateness for an occupational injury or illness (work-relatedness) from the discussion of whether a treatment proposal is generically credible (this separation of issues occurs in spite of regulations which specify that it should not, subsequent to the complexity that is often and unfortunately inherent in the systems). A generic focus for this chapter is also necessary in order for this chapter to exist, because efforts to discuss necessity and appropriateness specifically for occupational mental illness would quickly lead to a dead end (given the lack of scientific findings in support of the concept of occupational mental illness).

However, this adoption of a generic focus should not lead to issues of work-relatedness being overlooked. Scientific findings have reliably indicated that involvement in workers compensation leads to worse clinical outcomes (worse than the outcomes that are obtained when the treatment is delivered outside of the workers compensation system). (Rohling, 1995) (Binder, 1996) (Harris, 2005) Therefore, whenever a lack of work-relatedness can be demonstrated (as will usually be the case for a claim of mental illness), an opportunity is created to prevent involvement in workers compensation, and to thereby produce a better health outcome for the afflicted individual. Subsequently, ODG stakeholders should not mistake any mental health treatment recommendation as an endorsement for such treatment to take place within workers compensation. Stakeholders should engage in appropriate efforts to spare claimants from unjustified involvement in workers compensation, and to subsequently spare claimants from the harm that accompanies such involvement.

C. The fundamental importance of a credible diagnosis

In order for a treatment plan to be credible, a credible diagnosis must be established. This is due to the simple fact that treatment research is primarily organized by diagnosis. Once a diagnosis is credibly established, the scientific literature can be reviewed in order to determine what treatments have demonstrated effectiveness for that condition.

In order for a diagnosis to be even minimally credible, it must be based on the protocols that have been specified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). (American Psychiatric Association, 2000) That manual provides a comprehensive listing of all recognized mental illnesses, and diagnostic protocols for each disorder. These protocols are the gold standard for the diagnosis of mental illness. There is much more that could be done to establish greater credibility for a diagnostic claim (e.g., objective utilization of psychological testing, reviewing records from the claimant's entire life, etc.), but the DSM protocols are the necessary minimum.

D. The pervasive lack of credible diagnostic claims within workers compensation

Empirical investigations, conducted by this chapter's leader for an American Medical Association project, indicated that there is a pervasive lack of diagnostic credibility for mental illness claims within workers compensation.

For example, several agencies that gather workers compensation data nationally were asked to tabulate and report the most frequent occupational mental illness claims. The reports from each of these agencies included "diagnoses" which are not actually mental illnesses. Examples included "depression", "neurotic depression", "situational depression", "postconcussional disorder", "chronic pain", "mood disorder due to chronic pain", "chronic pain syndrome", and "mood disorder due to work related injury".

Readers who are not mental health specialists might be surprised to find out that these diagnostic labels are not actually mental illnesses. An explanation follows: The gold standard for mental illness diagnosis is the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. (American Psychiatric Association, 2000) This manual contains a comprehensive listing of all recognized mental illnesses. That list of mental illnesses does not include "depression", "postconcussional disorder", "chronic pain syndrome", or any of the other diagnoses that were quoted above.

In order to illustrate the importance of this issue, the example of "depression" can be discussed in greater detail. Depression can be a perfectly normal part of human existence, and as such it would not represent a mental illness, and would not warrant treatment (for example, antidepressant medication is not effective for normal depression which is not part of a mental illness). Depression can also be a symptom of many different mental illnesses (but it is not a mental illness on its own). When it is a manifestation of mental illness, a diagnostic claim of "depression" does not provide a focus that would be sufficient to create a credible treatment plan. That lack of focus is demonstrated by a textbook report that depression is a symptom of at least 41 different mental illnesses. (Sadock, 2003) Because the scientific research regarding treatment for mental illness is stratified by diagnosis, a non-diagnosis such as "depression" actually creates an obstacle to creating a credible treatment plan. As just one consideration in regard to this issue, it can be noted that stakeholders would not be able to determine if treatment were needed for the depression that is associated with Schizophrenia, or if instead treatment were needed for the depression that is associated with Adjustment Disorder (these two diagnoses are drastically different from one another, and the associated treatment plans would also be drastically different from one another).

These reports from the various data collecting agencies were not surprising to this chapter's leader. Decades of experience with claims of occupational mental illness had created the impression that there was a prominent tendency for the involved clinicians to invent mental illnesses that do not actually exist. The data from the agencies (discussed above) actually appears to understate the extent of this problem. The agency data was often shaped by a reliance of ICD codes. The use of such codes camouflages some of the invented diagnoses, because computerized analysis of such codes would create the misleading conclusion that the claim involved whatever mental illness is associated with that code (rather than the invented diagnostic labels that the clinicians had actually utilized).

Subsequently, in order to investigate the actual nature of diagnostic claims within workers compensation, a sample of more than 600 workers compensation claims were

scrutinized (all involved diagnostic claims which had been established by a mental health specialist). Analysis of the clinical documentation from those files revealed that approximately 43% involved a diagnosed mental illness that does not actually exist. Frequent examples included diagnostic claims that were similar to the invented labels that were discussed above, as well as "anxiety", "occupational stress", "anxiety disorder due to work-related injury", "depression due to work related injury", "personality change due to occupational trauma", "alcohol abuse due to occupational stress", "work-related drug abuse", "chronic pain due to work-related injury", and "substance abuse due to work-related pain". Subsequently, based on this sampling and the aggregate reports from the various agencies, it is clear that occupational mental illness claims are afflicted by a trend toward invented "diagnoses". Such non-diagnoses prevent credibility from being established for any treatment plan.

That sampling of files also provided systematic verification of another trend that had been informally noted: a pervasive lack of utilization of diagnostic protocols, even when a recognized diagnosis was claimed. For readers who are not mental health specialists, the following explanation is provided: The American Psychiatric Association's Diagnostic and Statistical Manual provides a diagnostic protocol for every known mental illness. Those protocols are the gold standard for determining whether an individual has a mental illness, and which mental illness is involved. In order to justify a diagnosis of mental illness, the diagnostician must (at a minimum) document utilization of the relevant protocol, and a description of how the examinee's presentation satisfies the requirements of that protocol. In the sample that was reviewed for the AMA project, it was discovered that when an actual mental illness was being claimed, documentation of the protocol that would be necessary in order to justify that diagnosis was absent 91% of the time. In summary, even when a recognized mental illness is being claimed, the claim is almost never justified at even a minimal level.

Additionally, this file sampling also revealed another example of the pervasive lack of thoroughness for mental illness evaluations within workers compensation. This additional example involves the critical importance of assessing for personality disorders in workers compensation claims (especially claims which involve complaints of chronic pain). A personality disorder is a pervasive form of mental illness which is pre-existing by definition, and which leads to claims of distress or impairment even if an occupational injury does not occur. Scientific findings have indicated that the majority of chronic pain claimants in workers compensation have a personality disorder. Despite such indications that a personality disorder is probable for any chronic pain claimant, and the subsequent clear need to evaluate for this diagnostic category in every chronic pain claim, the file sampling revealed that this standard part of the diagnostic process is reliably avoided. In almost every file that was reviewed (>99%), this portion of the diagnostic process was either "deferred" without explanation and without documented follow-up, concluded with a claim of that there was no personality disorder without any documentation of utilization of the diagnostic protocols that would have been necessary in order to justify this conclusion, or simply not mentioned. Such incomplete diagnostic evaluations leave a significant gap in the information that is needed in order to create a credible treatment plan.

Such findings indicate that ODG stakeholders must apply intense scrutiny to the diagnostic claims, before they analyze the credibility of a treatment plan. It is only after a credible diagnosis has been convincingly established that the analysis of a treatment plan can be meaningful. Options for scrutinizing a claimed diagnosis include competent

file reviews and independent examinations by mental health specialists. If an independent examination is the chosen option, it should ideally include objective utilization of psychological testing, and a review of records from the claimant's entire life, as well as a diagnostic interview.

E. The need for independent review in determining necessity and appropriateness of treatment for a claim of occupational mental illness

This section discusses one final, critically important issue, in regard to determining whether a treatment plan is necessary, appropriate, reasonable, etc. for a claim of occupational mental illness. The starting point for such determinations is an independent evaluation or review. The need for independent review is established by professional standards that prevent treating mental health clinicians from credibly offering conclusions regarding work-relatedness, necessity, appropriateness, etc.

Discussions of the relevant standards have been published by the American Psychological Association, the American Psychiatric Association, and the American Medical Association. (Greenberg, 1997) (Hales, 2002) (Barth, 2005) A detailed discussion of this issue has been provided in the listed references. For the purposes of this introduction, the following summary is being provided: Treating mental health clinicians have an ethical obligation to refrain from forensic conclusions, including work-relatedness, necessity, appropriateness, etc., because engaging in the generation of such conclusions: creates a financial conflict of interest that is unique to treating clinicians; compromises the quality of the treatment that the clinician is attempting to provide; and deprives administrative and legal systems of the objectivity that they need in order to work properly. Additional literature has specified that it would be a violation of the ethics guidelines of the American Psychological Association and the American Psychiatric Association for a treating clinician to offer such conclusions (or any other forensic issues). (Reid, 1998)

Because of these professional standards, ODG stakeholders should not solicit or accept discussions regarding work-relatedness, necessity, appropriateness, etc., from treating clinicians. Such discussions should only be undertaken with independent reviewers, and/or through direct application of relevant science to any individual claim. Consistent with the issues that have been discussed previously in this introduction, it will be in the best interest of the claimant's health for stakeholders to secure such independent and scientifically credible review of a claim of work-relatedness (and any other forensic issues), before turning to the contents of this chapter for purposes of scrutinizing a treatment plan.

III. Specific Conditions

Major Depressive Disorder

Warning: It is extremely difficult to credibly justify a claim of work-relatedness for Major Depressive Disorder. Subsequently, individuals who are treated within workers compensation for this disorder are going to be at an elevated risk of unjustifiably being exposed to the reliably detrimental health effects of involvement in workers' compensation. Scientific findings have reliably indicated that involvement in workers compensation leads to worse clinical outcomes (worse than the outcomes that are obtained when the treatment is delivered outside of the workers compensation system). (Rohling, 1995) (Binder, 1996) (Harris, 2005)

Major Depressive Disorder, definition

Warning: this is a highly summarized definition that is not intended to provide a full understanding of Major Depressive Disorder. It is instead simply intended to provide readers with a simple overview.

The American Psychiatric Association's diagnostic manual (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Text Revision. Washington, D.C., American Psychiatric Association, 2000) defines Major Depressive Disorder as a mental illness that is characterized by one or more Major Depressive Episodes without a history of Manic, Mixed, or Hypomanic Episodes (some details that will help to provide an understanding of what this definition means are provided below). (American Psychiatric Association, 2000) This mental illness is typically manifested in phases - the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future.

The "major depressive episodes" to which the above definition refers are the phases when the symptoms are present. These episodes are defined as: (1) a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities; (2) the individual also experiences at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep disturbance, psychomotor agitation or psychomotor retardation, decreased energy, feelings of worthlessness or guilt, difficulty thinking/concentrating/making decisions, recurrent thoughts of death or suicidal ideation/plans/attempts; & (3) the symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks.

The portion of the definition which reads "without a history of Manic, Mixed, or Hypomanic Episodes" serves to separate Major Depressive Disorder from the Bipolar and Cyclothymic Disorders.

Major Depressive Disorder, diagnosis:

The essential core of the diagnostic evaluation is the protocol provided in the American Psychiatric Association's diagnostic manual. (American Psychiatric Association, 2000) The diagnostician should compare the claimant's presentation to all of the information in that protocol, including diagnostic features, associated features and disorders, course, and differential diagnosis.

The following examples of issues from that protocol are not intended to serve as a substitute for the full protocol. These examples are only being provided in order to give readers some idea of what the protocol involves, and to at least partially convey the complex nature of the protocol.

MDD is characterized by a history of one or more Major Depressive Episodes. These episodes are phases when the symptoms are present for most of the day, nearly every day, for at least 2 consecutive weeks.

Diagnostic features for such major depressive episodes include:

- A period of at least 2 weeks during which there is:
 - (1) a depressed mood, and/or
 - (2) the loss of interest or pleasure in nearly all activities;
- At least four additional symptoms drawn from a list that includes:

- (1) Changes in appetite or weight
- (2) Sleep disturbance
- (3) Psychomotor agitation (e.g., observable restlessness) or psychomotor retardation (e.g., observably moving more slowly than usual)
- (4) Decreased energy
- (5) Feelings of worthlessness or guilt
- (6) Difficulty thinking/concentrating/making decisions
- (7) Recurrent thoughts of death or suicidal ideation/plans/attempts

Course: This mental illness is typically manifested in phases - the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future.

Differential Diagnosis: The person with this disorder has not experienced any Manic, Mixed, or Hypomanic Episodes, (which would push the diagnosis toward the Bipolar and Cyclothymic disorders, instead of MDD). The symptoms cannot be attributed to any other mental illness, or to any general medical condition.

Psychological Tests (e.g., current editions of the Minnesota Multiphasic Personality Inventory, Battery for Health Improvement, Millon Clinical Multiaxial Inventory, Structured Interview of Reported Symptoms) can be used as an important adjunct to the diagnostic process, specifically for the purpose of introducing an objective element to a process that is otherwise completely subjective. (Bruns, 2001) (Butcher, 2004) (Millon, 2001) (Rogers, 1992)

Thorough Review of Claimant's History can ideally involve an examination of records from the claimant's entire life, and collateral reports. This thorough type of approach is preferable to relying on the report of the claimant, because scientific findings have consistently revealed that an examinee's report of his or her history is not a credible basis for clinical decision-making. (Barsky, 2002) (Lees-Haley, 1996) (Carragee, 2007)

Any such diagnostic evaluation (and associated treatment planning) should take place on an independent basis. (Barth, 2005) If the evaluation does not take place on an independent basis, then the clinician must avoid any discussion regarding forensic issues such as work-relatedness, disability, etc. (Barth, 2005)