

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

DATE OF REVIEW: January 20, 2009

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 psychiatrist, 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

Outpatient individual psychotherapy times six (6) sessions as related to the right index finger

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an industrial injury on xx/xx/xx when she slipped and fell. She reportedly landed on her right knee and hand/fist. According to a December 4, 2008 impairment rating report, the patient complained of immediate pain and swelling in the right knee, right hand, and index finger. The injury was described as a crush injury resulting in fracture of the right index finger at the MP joint. She underwent treatment in the form of medication, surgery to the joint of the right index finger, several sessions of physical therapy, and was placed in the right hand splint. The patient subsequently underwent open reduction internal fixation.

The patient underwent an initial behavioral medicine consultation of October 27, 2008. She had been referred by her treating physician to determine her needs. The physician asked that an evaluation take place of the patient's emotional status and subjective pain to assess the relationship to the work accident and to determine her suitability for progression to some sort of low level behavioral treatment.

She described her pain as average daily pain of 8/10 since the work injury. The level of interference her pain has on her recreational, social, and familial activities was rated at 5/10. The interference with the ability to work was 1/10. She denies having had emotional disturbances or psychological treatment impacting her ability to function prior to the work injury. She reported negative changes in her personal relationships. She endorsed both initial and sleep maintenance insomnia as she was currently sleeping five to six fragmented hours per night. In order to deal with a negative effects from her injury, she went on walks, worked puzzles, and completed word find books.

Upon evaluation, her mood appeared anxious and her affect was constricted. Her thought process was coherent. She rated symptoms numerically as follows: Irritability and restlessness 4/10; frustration and anger 2/10; muscular tension/spasm 2/10; nervousness and worry 3/10; sadness and depression 4/10; sleep problems 6/10; and forgetfulness/poor concentration 4/10. She was provided the following diagnoses: Axis I-adjustment disorder with mixed anxiety and depressed mood, secondary to the work injury. Axis II: No diagnosis. Axis III: Injury to right hand. Axis IV: Primary support group and occupational. Axis V: GAF= 65 (current), estimated pre-injury GAF= 85+. The patient scored an 11 on the Beck Depression Inventory-II indicative of mild depression. She scored an 8 on the Beck Anxiety Inventory, indicative of minimal anxiety.

Problem areas were identified as personal physical illness or injury and threat of job loss. Goals of CBT techniques were specified as enhancing range of coping skills and improved problem-solving skills. The goals also included reducing the various symptoms outlined above.

A request for psychotherapy was non-certified on November 24, 2008. The physician reviewer stated that a psychological evaluation noted an adjustment disorder with anxiety and depression. Psychological testing indicated minimal symptoms of anxiety and mild symptoms of depression. Subjective ratings were consistent with these minimal levels. The report stated that although the ODG recommend individual psychotherapy for the treatment of major depressive disorder and anxiety disorders, the current evaluation suggests that the level of distress would not justify treatment with individual psychotherapy.

The patient saw a designated doctor on December 1, 2008. The report noted that the patient is a xx year-old female who was pleasant and cooperative throughout the entire exam. The doctor opined that the patient could return to work as of December 11, 2008 without restrictions. He stated that the patient has not reached MMI but would be expected to on or about January 15, 2009. He advised continued physical therapy to increase range-of-motion of the right hand. Psychotherapy visits were not mentioned.

The records include a request for reconsideration dated December 10, 2008. The letter states that unfortunately, the area of injury is the patient's right hand and the patient is right hand dominant. She is experiencing marked difficulties with activities of daily living, including self grooming, household chores, yard work, and cooking. She reports pain interference with recreational, social, familial, and normal activities as 4/10 and reports an average daily pain level of 8/10. The letter goes on to repeat the information supplied in the initial behavioral medicine evaluation report. The letter states that in order to ensure that her psychosocial problems do not interfere with her prescribed rehabilitation, a request is made for a brief course of individual psychotherapy to address injury-related stressors. The belief is that instruction in coping skills and self management of her condition will lead to an overall better recovery from her injury, which is now over six months old.

The request for psychotherapy was again reviewed on December 17, 2008 and a non-authorization rendered. The reviewer stated that the proposed treatment is not supported by the submitted documentation. The reviewer noted that the evaluation suggests minimal anxiety and very mild depressive symptoms. Per the DSM-IV, the diagnosis of adjustment disorder requires marked distress that is in excess of what would be expected from exposure to the stressor or significant impairment in social or occupational functioning. The report states that in an individual who is two to three months status post surgery, many of the symptoms that are likely identified by the depression scale are normal consequences of pain and noted to be related to the pain by the evaluator and not a mood disorder such as disturbed sleep due to pain and limitation in activities due to hand pain.

In reviewing the physical therapy records, a November 12, 2008 physical therapy note states that the patient is tolerating increases in the program without increases in pain. She reports pain only with increases with manual stretching. On November 13, 2008, she was noted to be progressing with increased range of motion and strength. A note dated January 8, 2009 states that the patient tolerated programs without complaints and without increased pain after therapeutic exercise. The report states that the patient will benefit from continued therapy to increase range-of-motion and decrease pain.

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

As noted below, the ODG states that patient should be screened, including fear avoidance. The submitted documentation does not include the results of a fear avoidance beliefs questionnaire. In addition, the guidelines state that initial behavioral therapy for at risk patients should be physical therapy for exercise instruction. A separate psychotherapy CBT referral should be provided after four weeks if there is lack of progress from physical therapy alone. However, the physical therapy records reflect that the patient had progressed with such therapy. In fact, the designated doctor recommended continuation of physical therapy treatment with no mention of the need for psychological intervention. Further, the patient's scores on the Beck Depression Inventory and Beck Anxiety Inventory did not demonstrate significant levels of anxiety or depression. Given these factors, my determination is to uphold the previous decision to non-certify the request for outpatient individual psychotherapy times six (6) sessions as related to the right index finger.

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
- 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 (2009)/Pain Chapter:

Psychological treatment:

Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested:

Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention.

Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy.

Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005)

Official Disability Guidelines (2009)/Pain Chapter:

Behavioral Interventions:

Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See the Low Back Chapter, "Behavioral treatment", and the Stress/Mental Chapter. See also Multi-disciplinary pain programs.

ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain:

Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ).

Initial therapy for these "at risk" patients should be physical therapy for exercise instruction, using a cognitive motivational approach to PT.

Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from PT alone:

- Initial trial of 3-4 psychotherapy visits over 2 weeks

- With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions)

With severe psych comorbidities (e.g., severe cases of depression and PTSD) follow guidelines in ODG Mental/Stress Chapter, repeated below.

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)

Extremely severe cases of combined depression and PTSD may require more sessions if documented that CBT is being done and progress is being made. Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental disorders, according to a meta-analysis of 23 trials. Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders. (Leichsenring, 2008)