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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 08/24/2010

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 Psychiatry Doctor, 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 6 sessions over 8 weeks

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

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 03-10-10 Initial report from Dr.
- o 04-09-09 Physician Visit Transcription reports through 06-02-09, 6 reports from Dr.
- o 04-09-10 Follow-Up Report from Dr.
- o 05-12-10 Mental Health Eval/Treatment Request from Dr.
- o 05-12-10 Follow-Up Report from Dr.
- o 05-18-10 Neurological ElectroDiagnostic Exam from Dr.
- o 05-18-10 Musculoskeletal Diagnostic Ultrasound report from Dr.
- o 06-16-10 Initial Diagnostic Screening from Dr.
- o 06-25-10 Pre-authorization request from A., MS, LPC
- o 06-30-10 Adverse Determination letter from
- o 07-24-10 Request for IRO from the Claimant
- o 07-27-10 Adverse Determination letter on Reconsideration from
- o 08-04-10 Confirmation of Receipt of Request for IRO from TDI
- o 08-04-10 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male who sustained an industrial injury to the elbow, wrist and hands on xx/xx/xx when lifting a heavy wall. About a month prior to this injury, the patient injured his left hand and underwent a left hand surgery. About 3 years prior there was a car accident with a shooting and he had gunshot wounds to the left hip, thigh and left chest area. The patient is 5' 5" and 230 pounds.

Physician treatment notes for the period of April 9, 2009 and June 2, 2009 describe the patient's treatment: The patient has a diagnosis of forearm strain and wrist tenosynovitis. He is using Naproxyn 500 mg. 6 sessions of PT will be scheduled (04-09-09).

He has had PT and feels better. He has pain on the bilateral dorsal (posterior) aspect of both forearms. Schedule for PT 1 x 3 (04-13-09). He feels better after 6 visits of PT. He describes mild intermittent forearm and wrist pain. Diagnosis is wrist sprain (04-20-10). He reports numbness in both hands that limit his activities. He feels the pattern of symptoms is no better. He describes a burning pain. He is working full duties (04-29-10). He feels the pattern of symptoms is no better. He describes moderate aching pain of 6/10. No swelling or effusion is seen. He has full ROM and normal grip strength. There is normal median, radial and ulnar nerve function. Plan is return to regular activity (05-14-09). He was released by his company. He feels the pattern of symptoms is improving. He saw a hand specialist who injected the wrists with improvement of all symptoms, but still has frequent pain, numbness and night symptoms. He is using Naprosyn 500 mg po BID with food (06-02-09).

The patient was initially examined by his chiropractic provider on March 11, 2010 for tenderness and restriction at the right wrist and forearm area. He reports a pain level of 8/10 and a burning pain. He saw a specialist who ordered EMG/NCV and recommended PT. The patient is otherwise in good health. He does have gunshot wounds at the left hip, thigh and chest area with metal still in his body from an incident 3 years prior. He is not currently using any medications. He is currently working. He is alert and oriented x 3. He has some restricted motion at the right wrist. Right grip is weaker than left. There is decreased sensation in the right hand and fingers. There is tenderness at the right forearm. Phalen's and Tinel's are positive. Impression is, rule out CTS, muscle weakness and right wrist IDS. EMG/NCV and PT are recommended.

The patient was reevaluated by his chiropractic provider on April 9, 2010. He reports a constant pain of 7/10 in the bilateral wrists with numbness and tingling. He is scheduled for pharmacological management on 04/19/10. Right wrists motion remains restricted. Right grip strength is 68 pounds and left 105 pounds. He is right-handed. Decreased sensation is noted at the right hand and fingers. Tinel's and Phalen's are positive.

The most current reevaluation report from the patient's chiropractic provider is dated May 12, 2010. He reports no improvement with the PT. He describes feelings of burning and tingling in the fingertips. He is still pending pharmaceutical management and an NCV study. He feels depressed due inability to carry out ADLs. Right wrist motion is restricted. A decrease in muscle strength is noted. Right grip strength is weaker than left. Sensation decrease is noted in the right hand and fingers along the median nerve distribution. Tinel's and Phalen's are positive. He will continue PT, continue full duty, go ahead with pharmaceutical management, do a nerve study, return in four weeks. He is recommended for individual psychotherapy to address his depressive symptomatology.

Request for Mental Health Evaluation/Treatment was made on May 12, 2010 for significant mental stress, sleep disturbance, family problems, pain complaints, treatment planning and vocational evaluation/planning.

EMG/NCV was conducted on May 18, 2010 and given impression: Findings consistent with mild right carpal tunnel syndrome. The findings suggest an entrapment neuropathy of the left median nerve at the wrist. This may be due to a repetitive injury, ligament or muscle compression of the nerve pathway.

Diagnostic ultrasound studies of May 18, 2010 showed a normal study of the cervical and thoracic spine and the trapezius region.

The patient's was provided an initial diagnostic screening report by a psychological specialist with report dated June 16, 2010: He has a chief complaint of sleep disturbance, vocational concerns, psychological stressors and physical limitations. He is being screened for consideration in a chronic pain management program. He saw an orthopedic specialist on March 11, 2010 who provided a diagnosis of rule out carpal tunnel syndrome muscle weakness and right wrist IDS. He is not currently using any medication, although he occasionally will use an OTC medication. He reports feeling a lot of pain with stiffness in the fingers and "damaged nerves." He has never been fired from a job. He completed 11th grade and has worked a number of construction jobs. He has improved slightly since attending PT. He feels his injury is very bad/severe. He denies any substance abuse or history of psychosocial treatment. He does not smoke. He describes his activity level as having no important change since his injury. He is still working, cleaning outside, and playing with his son. He explains that the pain is there, but he tries to stay as active as possible without hurting his hand. He has recently gotten married and has a 9-month-old son. His wife is working. He is currently working. His mental status is essentially unremarkable. Impressions: He rates his pain as mild (2/10) and as numb and aching on the back and right arm and hand. He has a moderate level of worry and emotional response. He scored 24% (minimal disability) on the Disability Questionnaire. He has a moderate-serious level of sleep disturbance. He is experiencing mild depression. Diagnosis is Adjustment Disorder with Mixed Anxiety and Depressed Mood, chronic and occupational problem. Stressors include, physical health, occupational/work, economic/financial, primary support group/family, parenting and education/school. Recommendation is for 6 sessions of CBT to decrease depression, anxiety, sleep difficulty and assist in developing an appropriate physical functioning daily plan to reduce vocational stress.

Request for individual psychotherapy 6 sessions over 8 weeks was considered in review on June 30, 2010 with recommendation for non-certification. Per the reviewer, the patient underwent initial diagnostic screening on 06/16/10. Affect was appropriate to verbal content and showed broad range. Memory functions were grossly intact. BDI is 12 and BAI is 16. Diagnosis is Adjustive disorder with mixed anxiety and depressed mood, chronic. He is not currently using any medication. No surgeries have been reported. Treatment has included PT, e-stim, activity modification, epidural injection, medication management and EMG/NCV. Rationale for non-certification states, there are insufficient psychological indications to support individual psychotherapy at this time. Affect was appropriate to verbal content and showed broad range. Memory functions were grossly intact. BDI is 12 and BAI is 16. Given the current clinical data, the requested individual psychotherapy is non-certified.

Request for reconsideration individual psychotherapy 6 sessions over 8 weeks was considered in review on July 27, 2010 with recommendation for non-certification. The patient reports pain of 2/10 described as numbing and aching and located in his back and right arm and hand. He scored 22 on the sleep questionnaire, which indicates moderate to serious level of sleep disturbance. EMG/NCV has shown very mild findings of median nerve entrapment. Rationale for denial states, the patient has been working modified or full duty since the injury. He has mild Beck scores for anxiety and depression and is fully functional. He does not require pain medication. He does have sleep difficulty, although it is not clear why this is occupationally induced. It appears that

this patient has been supported and maintained in his physical and system dependency. A rationale for additional supervised treatment is not seen. The patient does not meet the criteria for IPC sessions. The provider subsequently contacted the reviewer with a call back and a peer discussion took place. The provider feels the patient has some elevated fear and avoidance cognitions. He has gotten a job in a produce department, which is less heavy. The provider continues to believe the patient need a course of IPC to help reduce his fear and avoidance, help with his sleep patterns, and help address vocational needs. Appeal rights were discussed.

Request was made for an IRO.

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

ODG: A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy.

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)

The patient is 5' 5" and 230 pounds and does. He hurt his wrists while raising a wall. He had a left wrist surgery about a month prior and has metal fragments in his body from a shooting incident of about 3 years prior. He used Naproxyn 500 mg and attended 6 sessions of PT with no relief reported, although later some benefit was attributed to PT. He was off work for a time and felt better. He also felt relief with wrist injections provided in May 2009. He initiated chiropractic management in March 2010. He has not used medications since at least that time, except for occasional OTC meds. He has positive Tinel's and Phalen's and weak grip strength of the right. Nerve studies of May 2010 showed findings consistent with mild right carpal tunnel syndrome. The findings suggest an entrapment neuropathy of the left median nerve at the wrist. This may be due to a repetitive injury, ligament or muscle compression of the nerve pathway. Mental health evaluation of May 2010 noted, a mild pain level (2/10), moderate worry and emotional response and minimal disability per the Disability Questionnaire. He has a moderate-serious level of sleep disturbance. He is experiencing mild depression. Diagnosis is Adjustment Disorder with Mixed Anxiety and Depressed Mood, chronic and occupational problem. Stressors include, physical health, occupational/work, economic/financial, primary support group/family, parenting and educational/school. Recommendation is for 6 sessions of CBT to decrease depression, anxiety, sleep difficulty and assist in developing an appropriate physical functioning daily plan to reduce vocational stress.

First line review rationale for denial states, there are insufficient psychological indications to support individual psychotherapy at this time. Affect was appropriate to verbal content and showed broad range. Memory functions were grossly intact. BDI is 12 and BAI is 16. Given the current clinical data, the requested individual psychotherapy is non-certified.

Second level reviewer noted, the patient has been working modified or full duty since the injury. He has mild Beck scores for anxiety and depression and is fully functional. He does not require pain medication. He does have sleep difficulty, although it is not clear why this is occupationally induced. It appears that this patient has been supported and maintained in his physical and system dependency. A rationale for additional supervised treatment is not seen. The patient does not meet the criteria for IPC sessions. The provider subsequently contacted the reviewer with a call back and a peer discussion took place. The provider feels the patient has some elevated fear and avoidance cognitions. He has gotten a job in a, which is less heavy. The provider continues to believe the patient need a course of IPC to help reduce his fear and avoidance, help with his sleep patterns, and help address vocational needs.

The patient is currently working in a lighter duty job. He does not use medications. He does not smoke and has never had psychosocial treatment. His pain level has been reported as mild. He does have continuing wrist symptoms and positive nerve studies. He does not appear to have been offered a carpal tunnel release. The ODG criteria indicate CBT combined with antidepressant medication is the Gold Standard treatment for MDD. The patient is not using medication and does not appear to have active MDD at this time. He would not then be a candidate for a cognitive behavioral program/treatment.

Therefore, my recommendation is to agree with the previous non-certification for individual psychotherapy 6 sessions over 8 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

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

The Official Disability Guidelines 2010 - Mental Illness and Stress, Cognitive behavioral therapy (CBT) 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). It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. 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. For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. 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.

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)