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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 11/15/2010

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

Additional individual psychotherapy 1 x 6 - 90806

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 05-25-10 Initial Behavioral Medicine Consultation from Dr.
- o 07-07-10 Psychological Testing and Evaluation from Dr.
- o 09-09-10 Treatment Summary/Reassessment from Dr.
- o 09-22-10 Initial Adverse Determination letter
- o 10-22-10 Adverse Determination letter for reconsideration
- o 10-26-10 Request for IRO from the Claimant
- o 10-26-10 Confirmation of Receipt of Request for IRO from TDI
- o 10-26-10 Notice to P&S of Case Assignment from TDI
- o 10-27-10 Response letter

PATIENT CLINICAL HISTORY (SUMMARY):

According to the medical records and prior reviews the patient is a female who sustained an industrial injury on Xx/xx/xx when she slipped and fell. She landed on her left shoulder, hip and head. She was seen by a physician and returned to work. After a few months of continuing pain she was taken off work.

The patient was provided an initial behavioral medicine consultation on May 25, 2010 to assess her emotional status. She initially was returned to work. After several months of working with pain she returned to the doctor and was taken off work for about 3 months. She was provided treatment including MRIs, x-rays, PT and pain medications. She was returned to light duty as a but the employer progressed her to regular duties against the physician's wishes. She has been recently taken off work a second time for 90 days to regain her strength. She is being assessed to suitability for behavioral care. She describes burning pain with pins and needles averaging 10/10. She had a prior neck surgery in 1998. She has been married for 10 years. She states the pain is so great her housework does not get done. She describes her current level of functioning as 35%. She has gained 20 pounds. She has fragmented sleep. Her mood was dysthmic and anxious. She feels irritable, frustrated, nervous and sad and has episodes of forgetfulness. She is given a diagnosis of Pain Disorder associated with both psychological factors and a general medical condition, chronic, secondary to work injury, neck injury, GAF of 58 with pre-injury GAF estimated at 95+. Recommendation is for a battery of psychological tests.

Per an Addendum testing showed a BDI-II score of 24 indicating moderate depression and a BAI score of 34 indicating severe anxiety. Her fear avoidance score (FABQ-W) was 34 indicating significant fear avoidance of work and significant fear avoidance of physical activity in general (FABQ-PA = 24).

The patient underwent further psychological testing and evaluation on July 7, 2010 with recommendation for 6 individual psychotherapy sessions and a consultation to consider psychotropic medications. Goals of psychotherapy include, reduction of maladaptive coping behaviors and thoughts, decrease BDI-II scores from 31 (severe) to 19 (mild) an BAI scores from 38 (moderate) to 12 (mild) and educate the patient regarding sleep hygiene.

The patient's treatment was summarized by her provider on September 9, 2010. The problems to be treated are depression, anxiety, pain cycle, poor sleep hygiene and cognitive distortions. Intervention strategies include education, CBT, hypnotherapy, promotion of self-advocacy and vocational. The patient is overall, engaged. Her pain, anxiety and irritability have been reduced from 10/10 on May 25, 2010 to 8/10 currently (08/30/10). Muscle tension has been reduced from 10/10 to 9/10. Depression and sleep have been reduced from 10/10 to 6/10. BDI-II has increased from 24 (moderate) to 32 (moderate) and BAI remains at 34 (severe). [On July 7, 2010 BDI was reported as 31 - severe and BAI as 38 - severe] She is applying the coping skill learned. She spends time out of the house job searching at the library. She is better able to deal with stressors. She continues to experience depression and anxiety. She is also making good progress in her individual psychotherapy sessions. Additional sessions are warranted. 6 additional sessions are prescribed.

Request for additional individual psychotherapy 1 x 6 - 90806 was considered in review on September 22, 2010 with recommendation for non-certification. 65 pages of medical records were reviewed. The patient was treated for a slip and fall injury. Imaging and PT were provided. She complained of average daily pain of 10/10 and sleep insomnia. She was noted to have a depression score of 24 and anxiety score of 34, FABQ-PA score of 24 and FABQ-RF score of 34. She was recommended for additional psychological testing including the MMPI-2-RF. On June 25, 2010 she complained of tingling in the bilateral hands with radiation into the forearms and shoulders. She did the MMPI-2-RF on July 7, 2010 with a valid profile. Note reported the patient reported somatic and cognitive complaints with significant emotional distress. She was recommended for 6 session of CBT. Diagnoses: Lumbago, other syndromes affecting cervical region, pain in joint involving shoulder region. Medications include Lortab, Soma, Naproxen and Restoril. A peer discussion was attempted but not realized. ODG recommends up to 13-20 visits of individual psychotherapy for patients who have made objective functional improvement with the initial 6 sessions of CBT. The clinical documentation submitted for review fails to demonstrate the patient has evidence of significant objective functional improvement to warrant continued treatment at this time.

Request for reconsideration additional individual psychotherapy 1 x 6 - 90806 was considered in review on October 20, 2010 with recommendation for non-certification. The patient was treated for a slip and fall injury. Mental health evaluation of July noted severe depression and anxiety with somatization, chronic pain, and fear avoidance beliefs. Psychotherapy and antidepressants were recommended. She has completed the approved 6 sessions of psychotherapy including cognitive psychotherapy and relaxation training. Her subjective reports have improved from 10/10 to mostly 8/10 but self-report on Beck Depression Inventory has worsened. Antidepressants have not been prescribed in spite of recommendation at evaluation. There is no explanation for this and the absence of medication is inconsistent with evidence based guidelines and impeding her response to treatment. Messages were left with the provider but there was no call back at the time the review is due. Request is not consistent with ODG and antidepressants need to be added before additional psychotherapy is approved.

Request was made for an IRO.

Carrier response to the IRO request: The patient has completed the approved 6 psychotherapy visits including cognitive psychotherapy and relaxation training. Her subjective reports have improved from 10/10 to mostly 8/10 but self-report on Beck Depression Inventory has worsened. Antidepressants have not been prescribed in spite of recommendation at evaluation. There is no explanation for this and the absence of medication is inconsistent with evidence based guidelines and impeding her response to treatment. Request is not consistent with ODG and antidepressants need to be added before additional psychotherapy is approved.

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

Per ODG: Psychotherapy for MDD (major depressive disorder): Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD.

Following her injury the patient continued working for several months. She returned to the doctor and was taken off work for about 3 months. She was provided treatment including MRIs, x-rays, PT and pain medications. She was returned to light duty

but the employer progressed her to regular duties against the physician's wishes. She has been recently taken off work a second time for 90 days to regain her strength. It is pertinent to note at this point that the injury occurred nine years prior. The patient has apparently been working regular duties (restrictions not honored) for an undetermined number of years, yet she reports at the May 2010 psychological consultation her current level of functioning is 35% and her pain level is 10/10, which is not consistent with the facts of her situation. As noted in the second-level review, psychological testing done on July 7, 2010 made treatment recommendations including 6 individual psychotherapy sessions and referral for psychotropic medication consultation. The patient has moderate [or severe] depression and severe anxiety [On July 7, 2010 BDI was reported as 31 - severe and BAI as 38 - severe]. The patient is not reported to be using any psychotropic medication. Despite high self-report of depression and anxiety confirmed with testing the recommended treatment has not been provided. Prior to consideration of additional psychotherapy, treatment with psychotropic medication needs consideration. At this time, the request is not consistent with ODG.

Therefore, my recommendation is to agree with the previous non-certification for additional individual psychotherapy 1 x 6 - 90806.

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 09-08-2010 Mental Illness and Stress chapter: Psychotherapy for MDD (major depressive disorder): Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD.

Recommended. Cognitive behavioral psychotherapy is a standard treatment for mild presentations of MDD; a potential treatment option for moderate presentations of MDD, either in conjunction with antidepressant medication, or as a stand-alone treatment (if the patient has a preference for avoiding antidepressant medication); and a potential treatment option for severe presentations of MDD (with or without psychosis), in conjunction with medications or electroconvulsive therapy. Not recommended as a stand-alone treatment plan for severe presentations of MDD. (American Psychiatric Association, 2006) See also Cognitive therapy for additional information and references, including specific ODG Psychotherapy Guidelines (number and timing of visits).

Patient selection. Standards call for psychotherapy to be given special consideration if the patient is experiencing any of the following: (1) Significant stressors; (2) Internal conflict; (3) Interpersonal difficulties/social issues; (4) A personality disorder; & (5) A history of only partial response to treatment plans which did not involve psychotherapy.

Types of psychotherapy. The American Psychiatric Association has published the following considerations regarding the various types of psychotherapy for MDD:

- Cognitive behavioral psychotherapy is preferable to other forms of psychotherapy, because of a richer base of outcome studies to support its use, and because its structured and tangible nature provides a means of monitoring compliance and progress.
- In contrast, psychodynamic psychotherapy is not recommended because it has specifically been identified as lacking scientific support, and is severely vulnerable to abuse because it can involve a lack of structure. (American Psychiatric Association, 2006)

Cognitive Therapy 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). (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)