



## **PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xx

**Gender:** Female

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Slip and fall.

**Diagnosis:** 309.28 Adjustment Disorder with mixed anxiety and depressed mood, 311 Depressive Disorder NOS, and V62.2 Occupational Problem.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

This female sustained a work related injury on xx/xx/xx. The mechanism of injury (MOI) stated that the claimant alleged she was fixing herself a plate (during break) and she sat her plate down proceeding to get a drink. She picked up the drink and slipped on a meatball and water on the floor. She stated her feet gave way (feet went from underneath her), she hit a chair and fell on her shoulder and back. It appeared from medical record that she had received conservative treatment as well as psychotherapy from counselor, LPC. The medical records indicated that the claimant had received at least 12 sessions of individual psychotherapy with inconsistent and little improvement. The medical records indicated that there were no real defined goals for the treatment as well. Psychologist Ph.D. performed a peer review on 10/20/10, with the requesting provider LPC.

Dr. indicated that there was a lot of confusion about the claimant's objective psychological data since initiating therapy. The available records indicated that over the previous twelve (12) individual therapy sessions, her Beck Depression Inventory (BDI) had decreased from 44 to 34, Beck Anxiety Inventory (BAI) had increased from 54 to 57, sleep had vacillated, pain level was 9/10, and she continued to report problems with fear-avoidance and having a disabled pain perception. There was admittedly only progress after 12 individual therapy sessions with depression and sleep; although both remained significantly problematic. Ms. requested 6 additional sessions of individual therapy. Dr. stated that given the lack of significant objective progress after 12 individual therapy sessions, the request did not appear to be reasonable and necessary, per the ODG for psychotherapy. DO, MS performed the reconsideration to the adversely determined request on 11/16/10, with requesting provider LPC. Dr. stated that the claimant's diagnoses, under this claim per her treating providers, reportedly included cervical disc injury with myofascial pain syndrome and neuritis, lumbar myofascial pain syndrome, left shoulder internal derangement and right knee internal derangement.

Dr. stated the patient had recently completed 6 individual therapy sessions and her pain level had reportedly remained the same but she had shown good improvement with her BDI decreasing from 44 to 32 and her BAI decreasing from 59 to 44. Dr. also stated that the claimant's sleep score had improved as has her fear avoidance issues regarding physical activity. Ongoing issues involved her pain perception and her fear avoidance issues regarding work. Ms. reported to Dr. that the patient was told she needed surgery but there were compensability issues which were difficult for the patient to deal with. Ms. also reported to Dr. that based on the claimant's progress to date in individual therapy, as well as ongoing issues, particularly with pain, depression, and anxiety, 6 additional individual therapy sessions were necessary. Dr. stated that although the request

appeared to be reasonable and necessary, per evidence-based guidelines, there was no clear end point concerning the claimant's treatment. Dr. stated that at over 2 years out, it did not appear as if any surgery was done under the claim, no progress towards functional recovery, and BDI and BAI scores were worse than reported at time of last UR in August, for additional individual psychotherapy. Dr. also stated that the claimant was reportedly on Cymbalta for depression and Xanax for anxiety. Xanax is not recommended for long term use. There was no discussion of co-morbidities. There was no surgical request under the claim for any of the multiple purported injuries. An injury date that is 2+ years old should have defined and detailed treatment goals with documentation of improvement in order to consider further treatment, according to the ODG for psychotherapy.

There was no evidence, in the available medical records, of a detailed treatment plan with definable goals and no documentation of stating progress and consistent improvement. The ODG for psychological treatment state, "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](#)) See also [Psychosocial adjunctive methods](#) in the Mental Illness & Stress Chapter. Several recent reviews support the assertion of efficacy of cognitive-behavioral therapy (CBT) in the treatment of pain, especially chronic back pain (CBP). ([Kröner-Herwig, 2009](#))." The Official Disability Guidelines (ODG), Treatment Index, 8th edition (web), 2010 – Cognitive Therapy for Depression states that "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).” Based on the records provided in the context of the current treatment plan, there was no reasonable expectation of significant lasting functional improvement with 6 more sessions of individual therapy and Dr. recommended denial of this request. Given the information received in the medical records, the two past reviews, and the ODG criteria, this reviewer agrees with the past reviews and the adverse determination is upheld. There was no evidence of objective functional improvement in the claimant.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.
  - Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, psychotherapy.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).