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DATE OF REVIEW: 03/01/2011

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

Individual psychotherapy visits: 6 sessions over 6 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 09-23-10 Patient Notes MD
- o 10-05-10 Initial examination report DC
- o 10-06-10 Patient Notes MD
- o 10-12-10 Patient Notes MD
- o 11-05-10 Electrodiagnostic studies
- o 11-12-10 Follow-up examination report from DC
- o 11-15-10 Mental health Evaluation/treatment Request, DC
- o 12-03-10 Initial Diagnostic Screening, MS. LPC
- o 01-05-11 Pre-authorization request MS, LPC
- o 01-11-11 Peer Review
- o 01-11-11 Adverse Determination letter
- o 01-15-11 Response to Denial Letter MS. LPC
- o 01-31-11 Pre-Authorization request MS. LPC
- o 02-07-11 Peer Review
- o 02-07-11 Adverse Determination for appeal letter
- o 02-09-11 Request for IRO from the Claimant
- o 02-14-11 Confirmation of Receipt of Request for IRO from TDI
- o 02-15-11 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 employee who sustained an industrial injury to the cervical spine on xx/xx/xx when he was picking up linen and fell. Treatment has included medications, conservative treatments and a surgery on the date of injury for repair of an odontoid fracture.

The patient was examined in Chiropractic on October 5, 2010. He was bumped while holding linens and fell down some stairs

causing injury to his cervical spine, back and bilateral shoulders. A trauma team noted an isolated C2 fracture which was stabilized and processed for surgery. He was discharged from the hospital and has a neurologic follow-up examination at the end of this week. He rates his pain as 3-7/10. He is wearing a hard cervical spine brace and using Percocet. He is 6'1" and 123 pounds. He has a positive Rhombberg sign. He is quite tender. He can heel and toe walk but has difficulty with balance. He will remain off work for 30 days. Records will be requested. He has an upcoming neurological examination.

Physician notes of October 6, 2010 indicate an initial (likely pain management) examination. He is now wearing a heavy plastic cervical collar. He has good ROM of both arms. He is using Percocet and Colace. He is prescribed Miralax and Norco. On October 12, 2010 he was taken off the Norco as he was not tolerating this medication. He was given Dalmane for better sleep and will continue the Percocet.

Nerve studies done on November 5, 2010 showed a normal upper extremity study.

On November 15, 2010 request was made for mental health evaluation and treatment for agitation, anxiety, depression and sleep disturbance per a check-the-box format form.

The patient was reevaluated by his chiropractic provider on November 12, 2010. His pain varies from 2-6/10. He notes the medication management has been helpful as well as rest and stretching of his lumbar spine. His neck pain continues to radiate into his arms and superior head. His daily activities are affected, as is his sleep. His cranial nerves are intact. Right upper extremity reflexes are asymmetric. General upper extremity strength is 4/5. The thoracic and lumbar spine is unchanged. He will remain off work for two weeks. He needs a new hard cervical brace as his is loosening. He has an EMG/NCV planned. He will be seen soon for MMI determination. He will see a neurosurgeon next week. He also has a lumbar and cervical orthopedic exam scheduled.

Physician visit notes dated November 30, 2010 indicate his pain medication is helping. Percocet works better than Hydrocodone and no other meds are needed. The treatment plan indicates the patient will continue medication management and will be referred for follow-up examination regarding the cervical spine and for orthopedic examination of the lumbar spine to include lower levels of care for the low back such as epidural injections or interventional pain management. He has positive findings for L5 radiculopathy and should have a lumbar MRI.

The patient was assessed psychologically on December 3, 2010. He fell and hit his neck on the right side on concrete steps. He was seen in ER. He had a surgery for a C2 fracture. CT scan had shown an odontoid process fracture. The surgery included C1-2 fixation with hardware. Post-op CT scan showed interval fixation of Type II dens fracture with no evidence of hardware failure and multiple degenerative changes resulting in central canal stenosis at C5-6. He is using a back brace. His treating physician is recommending he participate in individual counseling. He is currently awaiting recommendations regarding additional cervical spine surgery. He denied a history of psychological/psychiatric symptoms or substance abuse. He has been married for 16 years and denies any relationship problems. He does not smoke. He feels his medical condition is quite severe. Since the injury he has begun to feel negative stress in his role as the provider, the husband, and as the father. He believes he needs further education and training for returning to his job. His job is still available to him. The employer has shown support and respect, which has helped him have confidence in returning to work. His financial status has decreased significantly. Testing indicates elevated levels of avoidance and fear related to his work-related injury and the impact of his pain on his current level of physical functioning. He reports the severity of his pain as horrible. Pain interferes with his activities. His BDI II score is 19 (moderate to severe). His BAI score is 12 (mild anxiety). He has extreme sleep difficulty. Impression is Adjustment Disorder with Mixed Anxiety and Depressed Mood. GAF is 58 compared to 80 pre-injury. Individual psychotherapy is recommended to decrease his BDI and BAI scores, improve sleep and reduce job stress and develop an appropriate vocational plan.

On January 5, 2011 request was made for 6 sessions of individual psychotherapy for agitation, anxiety, depression and sleep disturbance per a check-the-box format form.

Request for individual psychotherapy visits: 6 sessions over 6 weeks was considered in review on January 11, 2010 with recommendation for non-certification. Per the reviewer, the patient is status post a cervical surgery and is using Percocet, Hydrocodone, Neurontin, Dalmane and Miralax. The patient underwent a psychological evaluation on November 5, 2010 with request for six sessions of psychotherapy. However, the reviewer notes the patient is in an acute state about 3 months post injury and there is no evidence that his psychological symptoms constitute a delay in the usual time of recovery. ODG indicates that with acute pain, "pain is still related to tissue damage" and "is not yet compounded by the motivational, affective, cognitive, and behavioral overlay that is often a frustrating aspect of chronic pain." Per the reviewer, this is a new injury including recent surgery and the patient is actively involved in the continued evaluation and treatment of this new injury. At this time, there is no reason to believe that the current active rehabilitation will be insufficient to restore functional status. There is no evidence that the reported psychological symptoms constitute a delay in the "usual time of recover" from the acute injury. He is not at risk for delayed recovery. The request is not consistent with the requirement that psychological treatment only be provided for "an appropriately identified patient." A peer discussion was realized.

Appeal was made per letter of January 15, 2011: In the initial Diagnostic Screening performed on 12/03/10 the patient completed the following assessments: Fear-Avoidance Beliefs Questionnaire, Patient Pain Drawing, Pain Experience Scale, McGill Pain Questionnaire, Beck Depression Inventory, Beck Anxiety Inventory, Sleep Questionnaire, Neck Disability Index Questionnaire,

Quality of Life Scale and Pain Disability Questionnaire. His scores on the BDI and BAI were both in the moderate category; so the focus should be on the items endorsed as it relates to independent functioning. He reported sadness, dissatisfaction, crying, irritability, weight loss, work difficulty and other mood issues. He reports being unable to relax fear of the worst happening, nervous, scared, and dizzy and light-headed. He is not taking any psychotropic medications at this time. He would benefit from participation in individual counseling in order to help him cope with his feelings attributed to his work related injury and related stressors in the area of physical health, occupational and financial as reported and noted in the psychological social stressors section on the report on page 5. The patient is scheduled for an orthopedic consult on January 25, 2011 and is waiting for his surgeon to release him for PT. He will be transitioned to a new provider depending on the consultation. ODG supports a trial of six sessions of CBT. Please refer to the patient's Initial Diagnostic Screening report pages 6 for specific related measurable treatment goals (decrease BDI score 8 points and BAI score 4 points, decrease Sleep Questionnaire by 10 points and "reduce job stress and develop an appropriate vocational plan for return to work.") The treatment plan states, 6 visits 1 x per week over 8 weeks.

Request for reconsideration individual psychotherapy visits: 6 sessions over 6 weeks was considered in review on February 7, 2011 with recommendation for non-certification. Per the reviewer, the patient is a male with date of injury xx/xx/xx. There is a history of neck and BUE complaints, following a reported fall injury. Treatment has included conservative care and a recent surgery with fusion. There is some indication that post-op PT is being requested. Current medications are Percocet, Hydrocodone, Neurontin, Dalmane and Miralax. The mental health evaluation of 11/05/10 finds impressions of adjustment disorder. However, the utilized psychometric instruments are inadequate/inappropriate to elucidate the pain problem explicate psychological dysfunction, or support differential diagnosis in this case, and there is no substantive behavior analysis to provide relevant diagnostic information. Appropriate treatment cannot be based on inadequate evaluation, i.e. "Mental health science is primarily categorized by diagnosis, therefore a credible diagnostic formulation is of the greatest importance for evaluation and treatment planning." [ODG 2011- Mental Illness & Stress] If the patient is to receive PT, there is no reason to believe, at this time, that such will be inadequate to restore pre-morbid or reasonable functional status. That is, there is no evidence for lack of progress from PT as a required indication for psychotherapy in this type of case [per ODG]. The stated goal to "reduce job stress" is not germane, as the patient is not working at this time. The above issues were not adequately addressed in the appeal letter of 1/15/11, nor in the peer discussion. There was also no call back from the provider within the designated time frame to clarify these issues.

Request was made for an IRO.

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

ODG- 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.

First level denial rationale noted that the patient is in an acute state about 3 months post injury and there is no evidence that his psychological symptoms constitute a delay in the usual time of recovery. At this time, there is no reason to believe that the current active rehabilitation will be insufficient to restore functional status. He is not at risk for delayed recovery.

Second line denial rationale noted, if the patient is to receive PT, there is no reason to believe, at this time, that such will be inadequate to restore pre-morbid or reasonable functional status. There is no evidence for lack of progress from PT as a required indication for psychotherapy in this type of case [per ODG]. The stated goal to "reduce job stress" is not germane, as the patient is not working at this time. The above issues were not adequately addressed in the appeal letter of 1/15/11, nor in the peer discussion. Also, the utilized psychometric instruments are inadequate/inappropriate to elucidate the pain problem explicate psychological dysfunction, or support differential diagnosis in this case, and there is no substantive behavior analysis to provide relevant diagnostic information.

The appeal notes, the patient is scheduled for an orthopedic consult on January 25, 2011 and is waiting for his surgeon to release him for PT. He will be transitioned to a new provider depending on the consultation.

The current referring provider's report of November 12, 2010 notes the medication management has been helpful as well as rest and stretching of his lumbar spine. His neck pain continues to radiate into his arms and superior head. His daily activities are affected, as is his sleep. His cranial nerves are intact. Right upper extremity reflexes are asymmetric. General upper extremity strength is 4/5. The thoracic and lumbar spine is unchanged. He will remain off work for two weeks. He needs a new hard cervical brace as his is loosening. He has an EMG/NCV planned. He will be seen soon for MMI determination. He will see a neurosurgeon next week. He also has a lumbar and cervical orthopedic exam scheduled. The most current secondary provider report (11/30/10) indicates the treatment plan includes continued medication management and referrals for follow-up examination

regarding the cervical spine and for orthopedic examination of the lumbar spine to include lower levels of care for the low back such as epidural injections or interventional pain management. He has positive findings for L5 radiculopathy and should have a lumbar MRI. There is no report from either provider that the patient has developed a mental illness or is unable to cope with his situation.

The patient is diagnosed with an Adjustment Disorder, with Mixed Anxiety and Depressed Mood. Adjustment Disorder is not included in the list of ODG Specific Conditions covered in the Mental Illness and Stress Chapter. It is noted that of the 10 assessments conducted by the psychologist only three of them are included in the list of 26 Psychological Evaluations listed by ODG (see below). In any case, while it is appreciated that the patient is in a scary and frightful situation with a traumatic injury, acute pain and ongoing medical treatment, the reports indicate the patient is in an acute care state with his condition appropriately attended to and improvement noted. He is down to one primary medication and is still wearing a hard brace. He does have a supportive wife and employer. Delayed recovery has not been established and mental health specialty input would be premature at this time.

Therefore, my recommendation is to agree with the previous non-certification for individual psychotherapy visits: 6 sessions over 6 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 02-24-2011: 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)

The Official Disability Guidelines 02-24-2011: Mental Illness and Stress: Psychological Evaluations:

Recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory, (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale - VAS.

The Mental Health Evaluation: 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.

D. Challenges to a correct diagnosis within workers compensation

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. 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).