

MATUTECH, INC.

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Notice of Independent Review Decision

Date: July 5, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

24 sessions of cognitive behavioral therapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Per TDI rules, I certify that I hold appropriate credentials to conduct this review. Summary of qualifications: Medical Doctorate (M.D.) degree from the University of Virginia, internship and residency in Pediatrics at UTHSCSA, Developmental Pediatric Fellowship at William Beaumont Army Medical Center in El Paso, Texas, residencies in both Psychiatry and Child and Adolescent Psychiatry at UTHSCSA. I am triple boarded in Pediatrics, Psychiatry and Child and Adolescent Psychiatry and have recertified in Child and Adolescent Psychiatry in 2012. I have an unrestricted license to practice medicine in Texas since 1977. I served as an expert witness for 10 years for Social Security Office of Hearings and Appeals and continue to work as a Consultative Examiner for the DARS. I maintain a private practice in general and child and adolescent psychiatry at the present time and have many years of experience in peer review.

REVIEW OUTCOME:

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Dr.

- Office visits (08/11/10 – 06/20/12)
- Review (05/29/12)
- Utilization review (06/21/12)
- Office visits (08/11/10 – 04/19/12)
- Review (07/29/11)
- Progress notes (01/30/12 – 03/20/12)
- Utilization review (06/21/12)

TDI

- Utilization reviews (05/25/12 – 06/21/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who on xx/xx/xx, was working at xx in the capacity as a xx. He was attempting to work with a strainer which removed sediment and impurities from light gas oil. After cracking two nuts, the strainer exploded resulting in an explosion and fire. The fire was considered a category 4 fire. After the explosion the patient was thrown backwards due to the impact of the explosion. He reported that he felt woozy and experienced tunnel vision but was unsure whether or not he was momentarily unconsciousness. He was drenched in oil from the strainer and indicated that some of the substance was in his mouth as well. He ran down several flights of stairs to notify the chief operator. He indicated that he was worried about the effects of swallowing some of the oil which caused him to vomit. He was terrified that he would catch on fire due to being drenched in the flammable substance so close to the proximity of the fire. He was assisted by a medical team and the fire department. The patient reported that he showered twice and was sent back for a third shower due to persistent chemical odor. He initially experienced elevated blood pressure and heart palpitations and was not allowed to drive until his blood pressure decreased. He eventually drove home but felt nervous and was shaking and crying. The patient was unable to sleep that night due to profuse sweating and intrusive images of the accident. That night he also experienced symptoms of pain in his neck and low back which radiated down his shoulder and arms and reported experiencing numbness and tingling in his fingers.

2010: On August 11, 2010, M.D., a psychiatrist, evaluated the patient for neck and lower spinal pain and progressive anxiety, depression and confusion. He was utilizing citalopram 20 mg for depression. On mental status examination, the patient reported flashbacks seeing visions of the explosion and fire that he experienced. He also had severe nightmares of being enveloped by fire. He reported that it was difficult to impossible to sleep at night and wandered around the house checking the doors to determine whether or not they are locked. He was somewhat paranoid and had headaches all the time. He feared that he had been involved in a toxic exposure. He was blamed for the explosion and was terminated. He had impaired concentration, insight and judgment. Psychological testing indicated marked emotional, cognitive and behavioral dysfunction. Dr. diagnosed posttraumatic stress disorder (PTSD) with depressive and psychotic features, chronic severe pain disorder, headaches possibly secondary to toxic exposure or traumatic brain injury. Dr. recommended cognitive behavioral therapy, medical group psychotherapy, medical biofeedback training and objective psychological testing.

The symptom inventory checklist showed very often fast heart beating, difficulty breathing, nausea or vomiting, poor appetite, diarrhea, dizziness or feeling faint, hot flashes or flushing, tingling in the arms or legs, blurred vision, ringing in the ears, lack of interest in sex, excessive sweating, feeling or detached from others, inability to express or show feelings, inability to remember recent events and guilt

feeling for or about the accident and daily trembling or shaking of hands or body, feelings of terror or panic, headaches, physical pain, nervousness (stress/anxiety), sleeping problems, nightmares, sensitivity to noise, irritability, changed personality, depression, crying spells, thinking about the accident and anger towards self or others for their part in the accident.

2011: On January 17, 2011, Dr. noted that the patient had ongoing anxiety attacks 3-4 times per week characterized by sweating, vomiting, shortness of breath and tremulousness. He continued to have nightmares on about the same frequency but the migraines had diminished and had been replaced with less severe headaches. The patient had undergone functional capacity evaluation (FCE) and evaluation by a designated doctor M.D. He had undergone MRI which confirmed two-level disc herniations at C4-C5 and C5-C6. Dr. recommended cognitive behavioral therapy, medical group psychotherapy and medical biofeedback training. He refilled citalopram, Zyprexa and Treximet.

In June, the symptom inventory checklist showed very often poor appetite, diarrhea, tingling in the arms or legs, blurred vision, ringing in the ears, feeling detached from others, feeling that he would not live long, inability to express or show feelings and guilt feeling for or about the accident, having feelings as if the accident were happening again and inability to recall important aspects of the trauma. He also had daily fast heart beating, difficulty breathing, trembling or shaking of hands or body, nausea or vomiting, dizziness or feeling faint, feelings of terror or panic, headaches, physical pain, nervousness (stress/anxiety), sleeping problems, nightmares, sensitivity to noise, irritability, lack of interest in sex, excessive sweating, changed personality, lack of interest in life, depression, crying spells, inability to remember recent events, thoughts about the accident, feelings of worthlessness, slowness in thought movements, difficulties in concentration, tiredness/weakness, difficulties in making decisions, feeling unreal or like another person, anxiety when around thing or situations which would remind of the accident/traumatic incident, flashbacks, avoidance of placed related to the accident, thinking about the accident and anger towards self or others for their part in the accident.

Psy.D., performed a psychological evaluation. He noted that the patient was referred to an orthopedic surgeon and had MRI which indicated herniated disc in the neck. He participated in physical therapy (PT) and underwent epidural steroid injection (ESI) in his neck on two occasions which benefited him for approximately one and a half months. He was then referred to Dr. a neurologist, for headaches and was sent to a pulmonologist due to smoke inhalation and light gas oil ingestion. Dr. treated him with group therapy, medication management, biofeedback and individual counseling for PTSD. He reported development of significant symptoms of anxiety associated with PTSD and difficulty sleeping and frequent nightmares and intrusive thoughts about the explosion. He indicated that he was too fearful to be in proximity to machinery as it made him nervous, fearful of another explosion and he became increasingly anxious when considering a return to work. He also reported that he felt anxious while driving and arrived for

his appointment two hours early after becoming lost several times. The patient was utilizing citalopram, Zyprexa, Deplin, propranolol and topiramate. The patient reported significantly reduced cognitive and memory dysfunctioning and concentration difficulties. He had loss of appetite (and yet a weight gain of 30 lbs due to becoming sedentary). The patient became nauseous after his initial testing that caused him to vomit. He developed headaches and was fatigued. The patient scored 54 on Beck Depression Inventory (BDI) consistent with severe depression. He scored 62 on Beck Anxiety Inventory (BAI) consistent with severe anxiety including significant somatic complaints such as reduced ability to sleep, loss of appetite and reduced energy level. His responses to the FABQ demonstrated significant fear avoidance beliefs that work activity would lead to increased pain and reinjury. Dr. felt that the patient had significant feeling of depression, anxiety, PTSD, headaches, sleep difficulty, current medications and symptom exaggeration which were playing a role in cognitive impairment. Given his loss of emotional control, difficulty with attention and memory deficits would place himself and his coworkers at risk in his prior job. Dr. diagnosed chronic PTSD and chronic pain disorder with both psychological factors and a general medical condition. He opined that the patient was eligible for a psychological impairment rating as well as physical impairment rating and opined that the impairment would be 10-20%.

On follow-up, Dr. noted that the patient was utilizing Inderal to control panic attacks. He recommended continuing cognitive behavioral therapy, medical group psychotherapy and medical biofeedback and refilled citalopram, Zyprexa and Inderal.

On July 29, 2011, M.D., performed a designated doctor's evaluation (DDE) and noted the following treatment history: *"CT of the head performed on xx./xx/xx, revealed no acute intracranial abnormality. X-ray of the chest performed on June 15, 2010, revealed possible erosion, of the superomedial border of the bone. MRI of the cervical spine performed on August 5, 2010, revealed a 3-mm broad-based posterior disc protrusion at C4-C5 with mild superior extrusion extending behind the inferior corner of C4. There was mild impression on the ventral cord surface. There was a 2-mm broad-based posterior central disc protrusion at C5-C6 causing minimal impression upon the ventral cord at the midline. There was a 2-mm disc protrusion at C6-C7 flattening the ventral cord and ventral left C7 rootlet and a mild-to-moderate right osseous foraminal stenosis. There were 1 or 2 mm disc protrusions at C2-C3 and C3-C4 without indentation of the cord. MRI of the lumbar spine was unremarkable. The patient underwent an FCE on January 3, 2011. The evaluator opined that the patient was able to return to work at 20 hours per week with considerable restrictions. The treatment included PT for two months, work hardening program (WHP) for two weeks, massage for three weeks and two injections. Dr. opined that the patient was not at MMI and recommended individual therapy, medication management, biofeedback and group therapy.*

In December, Dr. noted improvement and recommended continuing cognitive behavioral therapy, medical group psychotherapy and medical biofeedback training. He maintained the patient on citalopram, Saphris and Inderal.

2012: From January through March, the patient had regular visits with Dr. He noted that the nightmares of fires and explosions continued. In a recent medical evaluation, Dr. concurred with the diagnosis and treatment plan.

In April, Dr. assessed impaired levels significantly impeding useful functioning with regards to activities of daily living (ADL), ongoing auditory hallucinations, flashbacks, nightmares and recollections which would distract him and impair his abilities with regard to persistence and pace and forgetfulness. The patient was utilizing multiple psychotropic medications for control of his symptoms including antidepressant and antipsychotic medications. The patient was isolated and withdrawn with regard to his social functioning. He had markedly impaired concentration. There was markedly impaired adaptation because of impairment. Dr. opined that the psychiatric component impairment rating would be 65%.

In May, Dr. noted objective functional improvement with stabilized and improved mood. The patient reported ongoing dysphoric episodes and crying spells. There was heightened general awareness, peeping out windows for threats, rechecking door locks, needing lights on while sleeping, ongoing injury related nightmares of fires and explosion. Dr. refilled citalopram, Saphris and Inderal and recommended cognitive behavioral therapy, medical group psychotherapy and medical biofeedback training for chronic severe pain.

Per utilization review dated May 25, 2012, the request for 24 sessions of cognitive behavioral therapy was denied with the following rationale: *"I discussed the case with Dr. The request for continued cognitive behavioral therapy is not clinically warranted, as no individual documented functional improvement has been noted with the initial treatment from February 2012 into March 2012. Without evidence of functional improvement and without documented coexistent physical therapy and exercise, the request cannot be certified. The guidelines indicate that an initial trial of three to four psychotherapy sessions is indicated over two weeks, with objective functional improvement a total of six to ten sessions can be performed over five weeks. Psychotherapy is not recommended to be performed alone and should be performed in accordance with an exercise instruction or physical therapy program."*

On May 29, 2012, M.D., performed a medical evaluation and rendered the following opinions: (1) It was necessary to determine if ongoing psychiatric presentation included an element of psychosis separate and distinct from PTSD; an evaluation by a comprehensive psychiatric RME to address this possibility was reasonable. (2) The current regimen for vascular headaches was allegedly ineffective. (3) Per ODG, most severe cases combined with depression cognitive behavior therapy should not exceed 50 sessions over a year or more. Biofeedback had probably exhausted its usefulness. An alternative medication for

vascular headaches should have been considered. (4) Future treatment with frequent visits to neurologist for a while would be reasonable for headaches. The psychiatric condition appeared static. PT, chiropractic care and DME were not reasonable.

On June 8, 2012, Dr. appealed for 24 cognitive behavioral therapy sessions.

On June 20, 2012, M.D., a neurologist, evaluated the patient for posttraumatic headaches. Dr. noted an early response to the Topamax increase which was done on June 6, 2012. The patient's headaches appeared to occurring a little less frequently. History was positive for hypertension and high cholesterol. Neurological examination showed impaired concentration with him repeating himself. Speech was tangential. Dr. diagnosed posttraumatic headaches, memory loss, cervicgia and PTSD. Dr. continued the topiramate and Treximet and recommended repeat neuropsychological testing to determine to what degree his deficits had improved.

On June 21, 2012, the appeal for 24 sessions of cognitive behavioral therapy was denied with the following rationale: *"The question becomes - based upon the lack of substantive progress, is continuation of the present treatment modalities for an additional 12 weeks justified. ODG guidelines indicate that treatment should be continued if there is an indication of progress. In this case progress is little to none. On the other hand, this man seems to be in marked distress psychiatrically. Discontinuation of treatment without other resources for alternative providers seems clinically imprudent. The treating psychiatrist reports that the patient is continuing to be very symptomatic with vague auditory hallucinations, compulsive checking and anxiety. He is currently treated with maximum doses of an antipsychotic and an antidepressant. When asked if the patient has been tried on alternative medication, Dr. reports that he was on Zyprexa in the past but the doctor's concern of metabolic syndrome led him to choose not to continue it. When asked if an independent psychiatric second opinion had been performed, Dr. replied that it had and that the consulting psychiatrist agreed with the present plan. When queried as to whether the patient is presently receiving any medical treatment for job/injury-related reasons other than three therapy visits weekly, the response was that he was not. The peer-to-peer phone call indicates that this patient has been in very frequent (three sessions weekly plus biofeedback) sessions since 2010. Although Dr. feels there has been slight improvement. When asked for more details, the doctor's description of the patient today is essentially the same as when he entered treatment in 2010. This patient is no longer in a multidisciplinary treatment program. The only treatment he is receiving is psychiatric. The duration of his treatment has long since exceeded the typical duration set forth in ODG. According to ODG, longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes. In this case an individualized care plan exists. However, the lack of improvement this far out would mean that there is no documentation of improved outcome. Based upon the lack of improvement, this patient fails to meet ODG for*

continuation and the requested extension of treatment with weekly sessions for another three months.”

On June 29, 2012, Dr. provided his justification for continued cognitive behavioral therapy.

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

This case must be analyzed under Appendix D of ODG: Documenting Exceptions to the Guidelines. According to Appendix D, the health care provider should document: (1) extenuating circumstances of the case that warrant performance of the treatment including the rationale for procedures not addressed in ODG; (2) patient co-morbidities; (3) objective signs of functional improvement for treatment conducted thus far; (4) measurable goals and progress: points expected from additional treatment; and (5) additional evidence that supports the health care provider's case.

Dr., the attending physician, appears to have addressed these issues in a fax sent to Matutech on 06/29/2012. According to Dr. Covert, the extenuating circumstances are that the claimant was blamed for starting an explosion and fire that resulted in a \$90 million dollar loss for his company. He was fired from his job after 20 years of work. Apparently, there is evidence that the explosion was actually caused by aged and not well-maintained equipment that should have been replaced and which the employer had refused to replace. Thus, the claimant's long and successful career was terminated by this incident over which he had no control. The patient seems to have co-morbidities of chronic pain syndrome, chronic headaches, and attention problems and memory loss. A neurologist, Dr., has recommended further testing to evaluate further these areas. The issue of functional improvement was discussed by several of the reviewers. The claimant did state to Dr. on May 29, 2012, that he felt 50% better since starting psychotherapy. Dr. gives some specifics, specifically that his frequency of nightmares and panic attacks had decreased, that his mood had improved and stabilized and that he was less paranoid and better able to participate in activities of daily living. Dr. does not provide any measurable goals and points expected from additional treatment. He does cite a report from Dr. who states that "Discontinuation of treatment without other resources for alternative providers seems clinically imprudent."

In conclusion, it seems that Dr. has met the majority of ODG requirements under Appendix D for approval for continued care. It is a concern that he does not have any specific plan for the future of measurable goals for his patient. However, given the severity of the claimant's current condition, as Dr. states, discontinuation of treatment at this point would be unwise.

Therefore, I feel that the claimant should be provided with an additional 24 sessions of CBT. However, since the claimant's improvement is so slow and additional evaluations have been suggested that may suggest alterations in his

treatment to improve his outcome, I would suggest that the frequency of the sessions be reduced to once weekly. This will allow this current approval to continue for the claimant for 6 months. In this way, small but steady gains will be easier to detect and any changes in medications or other treatments will have time to become effective before the claimant's sessions are exhausted.

Finally, it is suggested that Dr. develop a specific care plan in accordance with ODG that provides measurable goals and expected time lines in which to achieve those goals. Without such information, further sessions cannot be approved.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES