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Notice of Independent Review Decision

**March 10, 2014**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Individual Psychotherapy 1 x 6 weeks

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

Psychiatrist

**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.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

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**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who on xx/xx/xx, sustained an injury to her face, right knee, right ankle, neck, back, and left wrist.

On November 13, 2012, performed a peer review. Following treatment history was noted: *On xx/xx/xx, the patient was working when she tripped and fell on a rug, landing hard on her left knee and also hitting her face up against a metal counter. She had immediate face pain, as well as sudden onset of severe left knee pain that started to swell during the remainder of the afternoon. She was evaluated at the (ER) after a fall and seen. The patient had marked edema and tenderness to palpation of the left kneecap with mild ecchymosis. She had*

tenderness to the left premaxillary area with mild hyperemia. X-rays of the knee showed a transverse nondisplaced fracture of the patella with anatomic alignment and position of the fracture fragments. It was noted that the radiology report stated right patellar fracture and evaluation and paperwork stated left patellar fracture. The patient was placed in a knee immobilizer and prescribed Norco and Aleve for pain control and was advised to followup with her primary care physician. A work release for one week was provided. On August 29, 2012, evaluated the patient and noted ecchymosis around the left eye and left cheek and chin with some swelling; swollen right knee, tenderness to palpation of the left patella and tenderness with movement. Diagnosis was patellar fracture of the right knee and a contusion of the face with a normal cranial nerves exam. The patient was to continue hydrocodone, knee brace and was referred to orthopedics. The patient could return to work on or about September 7, 2012. On September 7, 2012, noted continued bruising of the left side of the face but the swelling had decreased and the right leg was still in the immobilizer. Diagnosis was sprain of the left hand and cervicalgia. The patient was placed off work. On September 13, 2012, evaluated the patient for physical therapy (PT). Diagnoses were fracture of the right patella, cervical and left hand, wrist, lumbar, hip strain, right foot and ankle sprain. The patient was to wait for the ortho evaluation to continue for possible rehabilitation. She was to continue wearing the right knee brace and a left wrist brace. She also remained off work pending the ortho evaluation. On September 25, 2012, performed medical evaluation and opined that the patient had not reached maximum medical improvement (MMI). He stated that the patient was still awaiting an evaluation by an orthopedist for the patellar fracture and also PT. He stated that she was expected to do well in the program and that MMI would be re-examined in approximately three months. On October 02, 2012, a urine drug screen was unremarkable. On October 5, 2012, the patient was evaluated. He ordered a magnetic resonance imaging (MRI) of the right knee and referred the patient for PT. X-rays of the left knee showed bilateral medial and lateral joint space narrowing consistent with cartilaginous or meniscal deficiencies. On October 11, 2012, the patient was re-evaluated for evaluation for right knee. She reported mid cervical region pain with decreased range of motion (ROM), right knee pain, and pain in the musculature of the lumbar spine. placed her off work until she was evaluated by orthopedics. On October 16, 2012, the patient underwent initial rehabilitation evaluation On October 16, 2012, the patient was evaluated in the initial behavioral medicine consultation. evaluated the mental health status of the patient and diagnosed pain disorder associated with both psychological factors and general medical conditions; major depressive order, single episode, severe without psychotic features; and injury to head, neck, knee, and hip. recommended treatment with psychotropic medications and educating the patient about the pain cycle, helping her deal with her pain disorder. On October 18, 2012, an MRI of the right knee showed a nondisplaced horizontal fracture through the inferior patella without articular deformity. There was also a contusion or strain of the adjacent patellar tendon with no evidence of a tear. Mild chondromalacia was also reported throughout the knee with minimal joint effusion. Per a document dated October 19, 2012, from the Pain Specialists showed that the patient had a visit on September 29, 2012, in order to set up interventional and pharmacological means of managing the

*patient's pain. She was prescribed Norco. On October 26, 2012, discussed MRI results and diagnosed a fracture of the patella. He ordered PT. rendered the following opinions: The patient, on the date of injury of xx/xx/xx, suffered what appeared to be a right patellar fracture, cervical neck sprain, lumbar sprain, left wrist sprain, and right ankle sprain. She had received exhaustive and prudent treatment consisting of PT, frequent office visits, prescription narcotic medications, and behavioral health evaluations. At that time, the patient appeared to have received adequate care for the treatment of that work related condition. It should be noted that the patient was still in the process of recovery and a final disposition could not be made for another few weeks until a nonunion was ruled out. The patient did need further treatment and evaluations and also continued PT to allow the patient to heal properly and completely. It was more likely that the major depressive disorder was a result of the work related injury dated xx/xx/xx.*

*On March 14, 2013, performed a peer review and noted the patient was assigned 12% Whole Person Impairment (WPI) as of December 17, 1997 for complaints of posterior neck and left shoulder and low back. The patient had sustained injury to lumbar, cervical, right knee, and face on xx/xx/xx. The principle body parts included fracture of the right patella, cervical sprain, lumbar sprain and face contusion. On January 12, 2013, assessed 8% impairment based upon diagnosis of cervical sprain/strain, lumbar sprain/strain, fracture patella and contusion of head. opined that a more appropriate impairment rating would be DRE category I of the cervical spine, pain complaints only rather than DRE category II which Inclusion criteria include non verifiable radicular complaints of which there were no documentation, non uniform loss of ROM of which there was documentation, and continuous or intermittent muscle guarding observed by a physician which was not documented.*

*On September 30, 2013, the patient was prescribed individual counseling and psychological re-evaluation.*

*On November 26, 2013, performed a designated doctor evaluation (DDE). Following treatment history for injury dated xx/xx/xx, was noted: On December 3, 1996, the patient was evaluated for work related injury dated xx/xx/xx, and for complaints of right hip pain, right leg pain, left shoulder and left arm pain. Diagnosis was possible fibromyalgia syndrome. established MMI on November 22, 1998, and gave the patient a 0% impairment rating of the whole person. A letter reported the patient had back pain, neck pain, radicular type symptoms both consistent with carpal tunnel and tennis elbow and radicular symptoms emanating from her spine. Massage therapy abated most of these symptoms. reported that the patient had no significant degenerative changes of her cervical or lumbar spine and they were mild in nature. Related to the injury of xx/xx/xx, following information was noted: The patient had undergone x-rays of the right knee, facial bones, MRI of the lumbar spine, cervical spine and right knee. From September 13, 2012, through April 24, 2013, the patient was seen who continued conservative measures of care. The patient was noted to have presence of tenderness and restriction of motion related to the cervical spine and trapezius*

area with the left side being worse than the right side. The patient had bilateral anterior cervical tenderness extending through the anterior aspect of the chest. The patient had palpatory pain from T3 to T10 on the right side and lumbar tenderness at L3 through L5 and tenderness in the lunate of the right wrist extending into the thenar and the metacarpophalangeal (MCP) joint of the first digit. opined that the patient had reached MMI on January 17, 2013, with 8% impairment rating. It was noted had evaluated the patient and recommended an epidural steroid injection (ESI) and a thoracic spine MRI and continuing PT. performed a functional capacity evaluation (FCE) on March 5, 2013, which demonstrated the patient was functioning at a sedentary work level. Work hardening program (WHP) was recommended. Per note dated February 5, 2013, the patient had subjective decrease in sensation to cold on the left in the C6-C7 dermatome distribution. Diagnosis was cervical radiculopathy and degenerative disc disease (DDD). From March 30, 2013, through September 27, 2013, the patient was seen who continued conservative measures of care and placed her at restricted work on May 11, 2013. She was referred for consideration of a surgical remedy characterized by a cervical discectomy and/or cervical fusion. requested an MMI/IR evaluation on August 23, 2013, and referred the patient on September 27, 2013, for her cervical radiculopathy. opined that the patient had reached MMI as of August 23, 2013 and cervical radiculopathy was found to be not part of the compensable injury.

On January 9, 2014, the patient was evaluated for individual psychotherapy treatment re-assessment. The patient had been diagnosed with anxiety disorder NOS, somatic symptom disorder with predominant pain, persistent, moderate. She had been utilizing Escitalopram Oxalate and oxycodone-acetaminophen. It was noted that the patient's response to the treatment was positive. The patient was encouraged to utilize alternative holistic methods of reducing pain and anxiety symptoms rather than relying so much on pain medication. The patient was very receptive to clinician and was thankful she had someone to talk to about her pain and injury related issues. While she was shown progress in session and at home with reducing negative symptoms through utilization of relaxation techniques and abdominal breathing there was still some report of difficulty in coping. Therefore, she might benefit from additional help to improve self-efficacy. The patient seemed to be extremely frustrated and irritated that her pain issues had no been resolved. Her current pain level was 9, irritability was 9, frustration was 10, muscle tension was 9, anxiety was 8, Beck Anxiety Inventory (BAI) was 37 (previous was 23), depression level was at 8, Beck Depression Index (BDI-II) was 34 and sleep problems level was 8. The patient was noted to have chronic serious/severe stressors. In addition to dealing with her own injury related problems, the patient was also dealing with serious health care issues of her husband and being a mother to her young daughter. The summary of gains made: Patient had improved ability to cope with pain and limited mobility. The improved functionality had created a stronger sense of confidence which had contributed to the reduction of negative psychological symptoms; especially considering the increase in psychological stressors. She had implemented a wider range of coping mechanisms including improved social relations and relaxation techniques, to good effect and reduction of negative symptoms. While

the patient showed some moderate improvements the ongoing issues with her case and her pain had increased her frustration and anxiety. MS, LPC, opined that the patient should continue individual psychotherapy sessions. Goals for further improvement included 1) increase problem solving and assertiveness 2) improved physical demand level (PDL) such as walking, home exercise, social functioning, and family involvement 3) exploring return to work options and opportunities 4) improved range and ability to successfully implement coping mechanisms

Per utilization review dated January 20, 2014, the request for individual psychotherapy one session per week for six weeks was denied with the following rationale: *“Based on the clinical information provided, the request for individual psychotherapy 1 x a week x six weeks is not recommended as medically necessary. Per telephonic conversation the patient has not improved after 16 sessions of individual psychotherapy and four sessions of biofeedback. The patient’s individual psychotherapy is not supported.”*

On January 29, 2014, submitted a request for a reconsideration/appeal for the patient’s authorization to participate in a brief course of individual psychotherapeutic sessions. It was reported that the patient sustained injuries to her face, right knee, right ankle, neck back, and left wrist on xx/xx/xx. The patient was at work when she slipped and fell on the floor. Due to her multiple injuries, she was extremely frustrated and irritated that her pain issues have not been resolved. This had increased her depression and anxiety scores. In addition to dealing with her own injury related problems the patient was also dealing with her husband’s serious health care issues and being a mother to her young daughter. In total, she had completed 16 individual sessions and four biofeedback sessions since 2012. In these set of sessions she worked on trying to improve her ability to cope with pain and limited mobility. The improved functionality had created a stronger sense of confidence which has contributed to the reduction of negative psychological symptoms; especially considering the increase in psychological stressors. The patient had implemented a wider range of coping mechanisms including improved social relations and relaxation techniques, to good effect and reduction of negative symptoms. Clinician had encouraged the patient to utilize alternative holistic methods of reducing pain and anxiety symptoms (i.e. exercise, stretching, and relaxation techniques) rather than relying so much on pain medication.

Per reconsideration review dated February 11, 2014, the request for individual psychotherapy one session per week for six weeks was denied with the following rationale: *“Clinical History: The patient who sustained an injury on xx/xx/xx, when she fell. Past medical history: Prior injuries to neck include 1 in xxxx, xxxx and xxxx. In the xx/xx/xx, injury the patient sustained injuries to the right knee and cervical spine. Prior treatment included 10 sessions of physical therapy for the knee. Medications included muscle relaxers and opiate analgesics. The patient was seen for designated doctor evaluation on January 3, 2013. Physical examination at this visit revealed muscle spasms and tenderness to palpation of the cervical spine. Reflexes were symmetric and there were no apparent*

radicular findings in the upper extremities. MRI of the cervical spine on December 11, 2012, identified a small disc osteophyte complex at C5-C6 and C6-C7 and small disc osteophyte complexes from C4 to C7 with mild right and moderate left neural foraminal narrowing at C4-C5 and C5-C6. At C6-C7, there was left mild left neural foraminal narrowing only. The patient was recommended for epidural steroid injection (ESI) and continued PT in January 2013. The patient reported weakness and numbness in the left hand. Clinical evaluation on March 6, 2013, reported some initial relief with epidural steroid injections. It was unclear where these injections were performed. Physical examination revealed mild weakness in the left deltoid with negative Spurling signs. There was sensory loss to the right in a C6 dermatome. The clinical note dated May 3, 2013, details the patient rating her pain as 6/10. The note does detail the patient having previously undergone a cervical ESI which did provide 50% relief for two months. Upon exam tenderness was noted with extension at the C4-C7 levels. The patient was noted to have 4/5 strength on the left, specifically with grip strength testing. Completed 16 IPT treatments, 4 biofeedback. Determination: This is an adverse determination. Per the physician advisor the requested services have been denied as not medically necessary and appropriate. A trip and fall with multiple body area complaints, although many have been disputed as well. She has been treated with PT, ESI, and medications, but has continued pain and high level of reported disability. She has prior neck injuries in xxxx, xxxx, and xxxx with impairment rating given. Placed at MMI for this injury by designated doctor in December 2013 with 8% IR. She has also been diagnosed major depression and pain disorder, receiving 16 sessions of psychotherapy and 4 sessions of biofeedback from November 2012 through December 2013. A number of cognitive behavioral interventions were initiated, as well as antidepressants. Past reports totaling 55 additional pages were sent as part of peer-to-peer review process, and indicate she improved over the first 12 session in late 2012 to mid 2013. She returned in late 2013 with moderate-to-severe self-reported symptoms again, and over the course of the last six visits her reports of depression, anxiety, and other psychological problems have increased. This is attributed to frustration with the fact her pain has not resolved, as well as family issues. The issues of accepting any permanent effects of her injuries should have already been dealt with in therapy focused on injury-related stressors. In addition she has had sufficient opportunity to learn and independently apply cognitive behavioral therapy to manage her expectations, attitude and mood. It is also noted she is on a relatively low dose of an antidepressant with no indication of consideration of revision. Necessity for more of the same therapy is not supported given these factors. This was discussed with and accepted on February 6, 2014.”

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

The specific issue to be addressed by this review is whether or not the patient would benefit from an additional 6 sessions of IPT.

The patient's history reveals that she had an initial Behavioral Health evaluation performed on 10/16/2012. evaluated the mental health status of the patient and diagnosed pain disorder associated with both psychological factors and general medical conditions; major depressive order, single episode, severe without psychotic features; and injury to head, neck, knee, and hip. recommended treatment with psychotropic medications and educating the patient about the pain cycle, helping her deal with her pain disorder.

There does not seem to have been any further behavioral health treatments after this initial mental health intervention until 01/09/2014, when she was evaluated at Clinic for individual psychotherapy treatment re-assessment. The patient had been diagnosed with anxiety disorder NOS, somatic symptom disorder with predominant pain, persistent, moderate. She was noted to be receiving Escitalopram 20 mg. at the time of this evaluation. She received 8 sessions of IPT and it was noted that the patient's response to the treatment was positive. The patient was encouraged to utilize alternative holistic methods of reducing pain and anxiety symptoms rather than relying so much on pain medication. The patient was very receptive to the clinician and was thankful she had someone to talk to about her pain and injury related issues. The improved functionality had created a stronger sense of confidence, which has contributed to the reduction of negative psychological symptoms, especially considering the increase in psychological stressors. The patient had implemented a wider range of coping mechanisms including improved social relations and relaxation techniques, to good effect and reduction of negative symptoms. Clinician had encouraged the patient to utilize alternative holistic methods of reducing pain and anxiety symptoms (i.e. exercise, stretching, and relaxation techniques) rather than relying so much on pain medication.

MS, LPC, opined that the patient should continue individual psychotherapy sessions. Goals for further improvement included 1) increase problem solving and assertiveness 2) improved physical demand level (PDL) such as walking, home exercise, social functioning, and family involvement 3) exploring return to work options and opportunities 4) improved range and ability to successfully implement coping mechanisms

The insurance company reviewer denied the request for the additional 6 sessions of IPT. The reviewer stated that the patient "has also been diagnosed major depression and pain disorder, receiving 16 sessions of psychotherapy and 4 sessions of biofeedback from November 2012 through December 2013. A number of cognitive behavioral interventions were initiated, as well as antidepressants. Past reports totaling 55 additional pages were sent as part of peer-to-peer review process, and indicate she improved over the first 12 session in late 2012 to mid 2013. She returned in late 2013 with moderate-to-severe self-reported symptoms again, and over the course of the last six visits her reports of depression, anxiety, and other psychological problems have increased. This is attributed to frustration with the fact her pain has not resolved, as well as family issues. The issues of accepting any permanent effects of her injuries should have already been dealt with in therapy focused on injury-related stressors. In addition

she has had sufficient opportunity to learn and independently apply cognitive behavioral therapy to manage her expectations, attitude and mood. It is also noted she is on a relatively low dose of an antidepressant with no indication of consideration of revision.”

The reviewer is correct that from 2012 through 2014, the patient has received at least 16 sessions of IPT. However, the initial 12 sessions did result in improvement of the patient’s symptoms. After a significant lapse of time, the patient was reassessed and found to have additional mental health needs, which were impacting her ability to regain useful function. These factors included increased stress and frustration at not being able to achieve remission of her pain and regain her previous level of functioning. Thus, the treatment sessions initiated in 2014 should be considered as a completely separate event from those provided almost a year earlier. First of all, there is a considerable temporal lag, which means that the treatment must be restarted. Secondly, the treatment was tailored to address additional symptoms not present previously, but equally critical in helping this patient to regain the ability to function. ODG does advocate assessing for risk factors for delayed recovery, which is what the clinician did at the time of the reassessment. ODG also advocates additional sessions be allowed if there is evidence of progress being made. There is definite evidence of progress for the sessions in 2014, so it is reasonable to approve an additional 6 sessions as requested by the provider.

Additionally, the reviewer makes a statement that “It is also noted she is on a relatively low dose of an antidepressant with no indication of consideration of revision.” She is documented to be receiving 20 mg. of Escitalopram, which is the maximum dosage of this medication that is allowed by FDA.

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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**