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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Individual psychotherapy, four sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
American Board of Psychiatry and Neurology

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who worked as a XX. On XX/XX/XX, he reports he was down on his knee working when a person ran over a 16-foot 2x4 causing the 2x4 to be raised like a see-saw, hitting him in the face and nose and knocking him off his feet backwards, causing him to lose consciousness. He sustained injury to the head and neck.

On XX/XX/XX, XX performed a peer review and opined that per the medical records, the patient had been diagnosed with a nasal fracture, facial contusion, mildly deviated septum, concussion syndrome, closed head injury, neck injury not otherwise specified, cervicothoracic strain, cervical discogenic pain, reactive anxiety and depression, cephalgia, unspecified neurocognitive disorder, major depressive disorder, somatic symptom disorder and illicit drug use of marijuana. The XX/XX/XX, work-related event was a substantial factor in bringing about nasal fracture and facial contusion. The additionally claimed injuries, conditions and diagnoses could not be reasonably attributed to the work-related event. The care rendered for conditions not validated by the medical records was unrelated to the work-related event. The nasal fracture had healed and the facial contusion had resolved. ODG supported discharge from care and return to work regular duty.

On XX/XX/XX and XX/XX/XX, the patient was seen in monthly follow-up visits for neck pain, nasal pain and headache. Examination revealed tenderness over the nose and cervical pain on range of motion (ROM) in all directions. The diagnoses were nasal fracture, history of concussion, closed head injury and

cervical strain. Neurology consultation was pending. He was referred to an ENT doctor. He was currently in counseling and biofeedback therapy. The patient appeared stable for sedentary-type work. On XX/XX/XX, XX ordered x-rays and MRI of the cervical spine.

Per reassessment summary of individual psychotherapy (IPT) treatment dated XX/XX/XX, the patient underwent individual psychotherapy sessions at XX from XX/XX/XX-XX/XX/XX, with diagnoses of unspecified neuro-cognitive disorder, major depressive disorder and somatic symptoms disorder with predominant persistent and severe pain. On XX/XX/XX, the patient reported magnetic resonance imaging (MRI) had been done which showed two ruptured discs in the cervical area and that surgery had been recommended. In the last couple of months, the patient's stress level had increased, which was reflected by his scores in depression and anxiety. There had been delays in the CCH which delayed diagnostics and treatment. Consequently, he continued to experience his pain symptoms and was not able to function well while waiting and worrying. He had tried to remain optimistic but the wear and tear of waiting and not knowing what was wrong with his neck had taxed his inner resources. Recommendation was to continue IPT to address depression and anxiety and continue to teach and reinforce cognitive behavioral therapy (CBT) coping skills to deal with the psychosocial repercussions of his injury. Biofeedback session was advised to address severe headaches and sleep disruption.

On XX/XX/XX, XX referred the patient for individual counseling.

On XX/XX/XX, XX completed a Behavioral Health Treatment Preauthorization Request for IPT 1x4 weeks and biofeedback therapy 1x4 weeks.

On XX/XX/XX, per utilization review, the individual psychotherapy and biofeedback therapy x4 sessions each was denied.

From XX/XX/XX-XX/XX/XX, the patient attended outpatient medical rehabilitation (OMR)/neurocognitive rehabilitation program. The modalities included cognitive therapy group, group therapy, and individual patient coordination.

On XX/XX/XX, XX performed a Medical Record Review. He opined preauthorized cognitive rehabilitation would not be as a result of the original work injury and recommended an independent examination consistent with ODG especially because of contradiction of neurocognitive disorder with other psychiatric disorders.

On XX/XX/XX, the patient was seen for neck pain. Examination revealed tenderness and continued pain on ROM in all directions with no spasm. The diagnoses were cervical disc disease and possible closed head injury. XX recommended continuing OMR program.

On XX/XX/XX, the patient underwent urine drug screen (UDS), which was positive for barbiturates, and cannabinoids.

On XX/XX/XX, the patient was seen to assess progress regarding surgery to treat his central and foraminal stenosis at C6-C7. XX judged the patient was symptomatic at C6-C7, and his radiculopathy affected the left C7 dermatome and myotomal innervation. The diagnoses were cervical disc herniation and radiculopathy. The plan included anterior cervical discectomy and fusion (ACDF) at C6-C7.

On XX/XX/XX, XX performed a physical performance evaluation (PPE) and opined the patient **was able to return to work without restrictions**. XX recommended continuing the OMR program, and care with treating doctor. In his recommendations, he opined, the patient **was not capable of performing their job duties (without restrictions)** until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment.

On XX/XX/XX, the patient was seen for cervical pain rated at 8/10. Examination revealed decreased biceps reflex on the right. Surgery was being scheduled. The patient was recommended continuing follow-up with Neurosurgery.

On XX/XX/XX, XX saw the patient in a follow-up for cervical pain. Pain was aggravated by abduction of the left shoulder. There was a contested case hearing on XX/XX/XX. The patient was continuing outpatient brain injury rehabilitation program and continuing to see his pain management doctor.

On XX/XX/XX, XX evaluated the patient for follow-up of neck pain and head injury. Examination revealed still limited to about 30-degree or less of right and left rotation of the cervical spine but was moving much more freely than on the previous visit. The diagnosis was reactive anxiety and depression with associated head injury. Hydrocodone and Elavil were refilled. UDS was positive for marijuana and opiates.

On XX/XX/XX the patient was seen for reassessment for continuation in outpatient brain injury rehabilitation program. The diagnoses were major neurocognitive disorder, due to a traumatic brain injury, with behavioral disturbance, mild, major depressive disorder, single episode, severe without psychotic features and somatic symptom disorder, with predominant pain, persistent, severe. Recommendation was to continue in neurocognitive behavioral program in order to maintain the excellent progress and to increase functional tolerance.

On XX/XX/XX, XX performed PPE. The assessments included the patient had made objective improvements in ROM and dynamic lifting. The patient could not safely perform his job demands based on comparative analysis between the required job demands and his current evaluation outcomes. XX recommended continuing care with his treating doctor and continued participation in the outpatient brain injury rehabilitation program (OBR program).

On XX/XX/XX, and XX/XX/XX, XX indicated the patient was doing extremely well with the OBR program. Examination revealed continued tenderness throughout the cervical and upper thoracic paraspinal musculature with hypertonicity noted. Hydrocodone, Zanaflex, and Elavil were refilled. The patient was recommended continuing the OBR program. UDS was positive for opiates.

On XX/XX/XX, and XX/XX/XX, XX saw the patient in follow-up of neck pain and recommended continuing the OBR program until completion. He also recommended modified work with no lifting over 10 pounds. It was noted that the patient was not currently working.

On XX/XX/XX, XX saw the patient in a follow-up for neck pain and brain injury. The patient reported doing somewhat better. He also stated that he was sleeping a lot better with the increased dose of amitriptyline. XX refilled hydrocodone and Elavil.

On XX/XX/XX, the patient was seen for reassessment. He was recommended to continue the neurocognitive behavioral program.

On XX/XX/XX, XX performed a PPE and opined the patient was able to return to work with restrictions. XX recommended continued care with the treating doctor and continued participation in the OBR program.

On XX/XX/XX, XX saw the patient in follow-up for continued cervical pain. It was noted the patient had an appointment for another MMI evaluation. He was currently not working. He had exhausted other treatment regimens including pain management. XX returned him to modified work with no lifting over 10 pounds.

On XX/XX/XX, utilization review was documented for OMR outpatient brain injury rehabilitation program additional 80 hours, which was denied.

On XX/XX/XX, XX performed a designated doctor evaluation (DDE) and gave the following opinions in different scenarios. Per scenario #1, the patient had reached Maximum Medical Improvement (MMI) date clinically on XX/XX/XX, and a whole person impairment (WPI) of 0% was assigned. Per scenario #2, #3, #4 and #5, the patient was not at MMI and expected MMI date was XX/XX/XX.

On XX/XX/XX, the patient was evaluated for a neuropsychological examination. The patient had impaired attention/working (concentration) and processing speed. The patient had not reached MMI from a TBI perspective. XX opined that the patient's IR appeared to be at the midpoint of the "Emotional and Behavioral Impairments" table (0-14%), "mild limitation of daily social and interpersonal functioning," but additional treatment could improve his IR.

On XX/XX/XX the patient was seen for follow-up of his neck pain. The patient's UDS was positive for opioids as appropriate. He was assessed with continued cervical pain with surgery pending and continued cognitive problems under the care of a psychologist. Hydrocodone and Elavil were continued.

On XX/XX/XX, per Notice of independent Review Decision, the previous adverse determination for OMR Outpatient Brain Injury Rehabilitation program additional 80 hours was upheld.

On XX/XX/XX, per XX, OMR discharge summary, the patient was discharged from outpatient brain injury rehabilitation program. He had completed 240 hours.

On XX/XX/XX, the patient was evaluated for cervical pain. XX stated further treatment was denied. The patient would be at statutory MMI in approximately one month. He was released to modified work with no lifting over 20 pounds.

On XX/XX/XX XX saw the patient in a follow-up for neck pain. The patient continued to have a lot of pain in the neck and was now finished with his program of care for his brain injury. The diagnoses were continued neck pain secondary to work-related injury and continued reactive anxiety and depression secondary to lack of improvement from significant neck and brain injury. XX recommended continuing psychotherapy. Hydrocodone and Elavil were continued.

On XX/XX/XX, XX ordered individual counseling for the patient.

On XX/XX/XX, the patient was evaluated for a health and behavioral reassessment at the directive of his treating doctor, XX, to assess his emotional status and to determine his suitability for some level of

behavioral medicine treatment and/or a return to work program. The patient reported injury to his head and neck on XX/XX/XX. He was initially treated at (ER) where Computerized tomography (CT) of the face revealed a nasal fracture. Further, he was diagnosed with a post concussion syndrome with a closed skull fracture. Neurologist noted severe, persistent headaches, dizziness, decreased short-term memory and nasal discharge. Magnetic resonance imaging (MRI) of the cervical spine dated XX/XX/XX, revealed a central disc extrusion at C6-C7 with central spinal stenosis. Electromyography (EMG) of the upper extremity dated XX/XX/XX, indicated the presence of moderate left C7 radiculopathy.

On XX/XX/XX, XX completed a Behavioral Health Treatment Preauthorization Request for IPT 1x4 weeks.

Per utilization review dated XX/XX/XX, XX denied the requested services with the following rationale: *"This patient has already completed 240 hours of an outpatient medical rehabilitation program with these providers beginning in XX/XXXX. The details of the previously approved submitted requests document that the prior program completed included cognitive behavioral interventions, individual psychotherapy, vocational counseling, educational group therapy, biofeedback, cognitive skills training, physical rehabilitation and medication management. After 240 hours of the medical rehab program completed, Fear Avoidance Belief Questionnaire (FABQ) scores were still maximal, and Beck Depression inventory (BDI), and Beck Anxiety inventory (BAI) scores still indicated severe anxiety and severe depression. Pain complaints remained high 8-9/10. Medication use still involves opiates (hydrocodone) and functional improvement is absent. It is safe to say that completion of the previously approved and completed 240 hours of outpatient medical rehabilitation with these providers was not successful as far as functional outcome measures are concerned. Thus since 240 hours was not successful. another 4 hours of individual psychotherapy will not make a clinically relevant difference. Lastly, ODG does not support lower levels of care after completion of a tertiary rehabilitation program such as the one that has already been completed."*

On XX/XX/XX, XX performed a record review. He concurred with the initial designated doctor, post DD RME physician, and with current DD conclusions that MMI for the nasal fracture and facial contusion was XX/XX/XX, with 0% WPI.

On XX/XX/XX, XX saw the patient for continued neck pain. He reported pain and trouble turning the head especially with driving. Hydrocodone and Elavil were continued and refilled. Follow-up on a monthly basis at least until he had a surgery was recommended.

On XX/XX/XX, XX completed a Request for Reconsideration/appeal of the patient's denied services.

Per utilization review dated XX/XX/XX, XX upheld the denial with the following rationale: *"The request was previously denied as the patient had already completed 240 hours of an outpatient medical rehabilitation program with providers beginning XX/XXXX. The details of previously approved submitted request documents of the prior program completed included cognitive behavioral intervention, individual psychotherapy, vocational counseling, educational group therapy, biofeedback, cognitive skills training, physical rehabilitation, and medication management. After 240 hours of the medical rehabilitation program completed, Fear Avoidance Belief Questionnaire were still maximal, Beck Depression Inventory. Beck Anxiety Inventory still indicated severe anxiety and depression. Pain complaints remained high (8/10 to 9/10). Medication use still involved opiates and functional improvement remained absent. It is noted that since 240 hours were not successful another 4 hours of individual psychotherapy would not make a*

clinical relevant difference and ODG did not support lower levels of care after completion of a tertiary rehabilitation program such as the one that had already been completed. The documentation provided for review still does not address 4 additional hours of individual psychotherapy would make a clinically relevant difference after 240 hours if a medical rehabilitation program has been completed in addition to the previously noted 9 psychotherapy sessions with 3 biofeedback sessions. Furthermore, there are no exceptional factors noted to support lower levels of care after completion of a tertiary rehabilitation program such as the one that has already been completed by the patient. Therefore, the request remains not supported. Peer to Peer calls were attempted, but a case discussion was unsuccessful. As such, the request for Individual Psychotherapy x 4 sessions (1x4) is non-certified."

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

The reviewer who denied the request for 4 sessions of IPT makes a reasonable case for why the requested service is not medically necessary. As stated, the patient has already undergone intensive treatment for his brain injury and psychological issues that included 9 psychotherapy sessions, 3 biofeedback sessions and 240 hours of treatment altogether, including CBT. As noted, the patient was judged to have reached MMI even though he still complains of pain, depression and anxiety. Of note is that the patient is not receiving psychopharmacological treatment of his anxiety and depression. He is receiving amitriptyline, 25 mg., 1 ½ qhs. This dosage is prescribed to help the patient sleep and is too low of a dosage to treat his emotional symptoms. A review of the record does not indicate that he has ever been given a trial of antidepressants. Some antidepressants, such as Cymbalta (duloxetine), not only treat anxiety and depression, but chronic pain as well. Given that the patient has already had many hours of psychotherapy to teach him coping skills, the next step should not be a repeat of the past treatments that have not worked. Rather, he now deserves a trial of a new approach, psychopharmacology. This would be in keeping with ODG.

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