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Notice of Independent Review Decision

November 15, 2012

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:

Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Medical documentation does not support 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:

TDI

- Utilization reviews (10/04/12, 10/26/12)

- Office visits (09/19/12 - 10/17/12)
- Utilization reviews (10/04/12, 10/26/12)

- Reviews (04/11/12 - 10/01/12)
- Diagnostics (04/11/12 - 08/28/12)
- Therapy (06/11/12 – 07/26/12)
- Office visits (07/02/12 - 08/07/12
- Utilization reviews (10/04/12, 10/26/12)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who injured her left knee. She went up a ladder and while coming down she slipped off the last step and hit the floor with her left foot. She felt severe pain radiating from her left knee.

On April 11, 2012, MRI of the left knee showed a subtle 1-mm subchondral impaction fracture of the central medial tibial plateau with surrounding marrow edema, complex tear of the medial meniscus with truncation of the free edge of the posterior horn, mild proximal medial collateral ligament (MCL) sprain, small joint effusion, small Baker's cyst, mild subcutaneous and popliteal fossa edema, moderate chondromalacia and mild degenerative joint disease (DJD) of the patellofemoral compartment, mild chondromalacia and DJD of the medial compartment and mild partial peripheral extrusion of the medial meniscus and red marrow conversion within the distal femur.

On June 4, 2012, noted that the patient was feeling a little better. She was able to put more weight on her leg. There was ongoing tenderness in the posterior aspect of the knee directly in the crease while bending. Examination revealed tenderness at the medial joint line and over the medial tibial plateau and medial femoral condyle. diagnosed left knee medial tibial plateau stress fracture and possible medial meniscus tear and chondromalacia medial and patellofemoral joint, hamstring sprain/strain which was still symptomatic and diffuse deconditioning of the left knee. He recommended therapy.

On June 11, 2012, the patient underwent physical therapy (PT) evaluation. The therapist noted that the patient was utilizing Pristiq, Abilify, Klonopin, Adderall, Nuru Gel and vitamin D. History was positive for previous fracture right femur broken at four places in the 70s, left ankle fracture in the 90s, left knee arthritis and depression.

PT was initiated in June 2012. The patient made slow progress. Her pain was decreasing. kept her off work through July and August 2012 because she had weakness and was unable to climb stairs.

On July 2, 2012, noted that the patient was doing better. She had a lot of pain posteriorly and laterally. The medial pain had gotten worse. The therapy was helping but she was unable to get the posterior hamstring laterally feel better. Examination revealed ongoing tenderness at the medial joint line, minimally tender medial tibial metaphysis, tenderness in the posterior lateral popliteal recess and tender hamstrings and gastrocs. Weightbearing x-rays showed bone-on-bone compartment with a little subluxation. administered a steroid injection.

On August 2, 2012, noted that the patient had two Doppler studies which ruled out DVT and cyst, MRI of the left knee, steroid injection of the left knee and eight sessions of PT. History was positive for depression, anxiety, and high cholesterol. Examination revealed mild effusion of the left knee, flexion to 115 degrees, extension to 0 degrees and pitting edema from foot to the knee. diagnosed left

knee sprain with probable internal derangement and left leg edema. He started naproxen and recommended evaluation by an orthopedic surgeon.

On August 7, 2012, evaluated the patient for left knee pain. He noted that the patient had some improvement from the injection. Examination revealed decreased ROM with tenderness over the medial aspect of the knee and the patella. diagnosed internal derangement of the left knee and referred her to an orthopedic surgeon.

On August 16, 2012, noted throbbing pain in the left knee. The patient reported no improvement with naproxen. Examination revealed left knee trace swelling and mild medial tenderness with flexion to 90 degrees and extension to 0 degrees. diagnosed left knee sprain and left knee internal derangement. He started Norco and recommended continuing naproxen.

August 28, 2012, urine drug screen was positive for clonazepam, hydromorphone, hydrocodone and clonazepam.

On August 30, 2012, noted ongoing left knee pain. The patient was scheduled to see orthopedic surgeon. She had lost her job. She was being seen by her primary care physician (PCP) for high blood pressure. History was positive for bipolar depression and sleep apnea. diagnosed left knee sprain with internal derangement and hypertension. He recommended seeing her orthopedics and PCP.

August 30, 2012, evaluated the patient for popping and clicking in the left knee. Examination revealed intact left knee ROM, positive McMurray's and diffuse soft tissue swelling. reviewed MRI that showed torn medial meniscus. He recommended left knee arthroscopy.

On October 1, 2012, performed a peer review. The peer review contained the following additional records:
"On April 6, 2012, the patient was seen who noted that the patient was on a stepladder when she lost her balance and stepped down with her left foot. She had immediate pain, spasms and tightness and some swelling. The patient was unable to bear weight because of pain. She was walking with a cane without a limp but had difficulty with weightbearing in the left lower extremity. X-rays of the left foot showed some arthritic changes. assessed left knee medial cruciate ligament (MCL) tear but there was concern for an occult fracture. He prescribed Toradol and hydrocodone and ordered magnetic resonance imaging (MRI). On April 25, 2012, venous Doppler studies were done which were negative. On April 25, 2012, noted that the patient went back to work on April 24, 2012, using a walker. She had knee pain and was concerned about DVT. On May 8, 2012, the patient was taken off work because there was no light duty available and she had pain and weakness due to fracture. On August 16, 2012, performed a peer review and opined that the most probable work compensable diagnosis was temporary exacerbation of chronic and advanced medial compartment degenerative arthritis of the left knee, although a medial tibial plateau fracture was interpreted because of bone marrow edema there was no description of fracture

lines in the location of the center of the tibial plateau. It was very unusual for a traumatic injury because it would usually be on the periphery of the plateau. The central aspect of the tibial plateau becomes involved after the peripheral rim has been fractured and displaced which was not the case here. Bone marrow edema without evidence of fracture lines was most consistent with degenerative bone marrow edema related to advanced grade IV bone-on-bone contact arthrosis and not a tibial plateau fracture due to acute trauma. The trauma was a typical activity of daily living, even If the lower extremity was jarred as described; i.e., stepping off the bottom rung of a ladder, the tibial plateau fracture would not be the anticipated result. The findings were most consistent with temporary exacerbation of a degenerative condition. No further treatment was necessary for the injury as there was substantial improvement by June 21, 2012. There was insufficient evidence for an acute focal pathoanatomic lesion that would be directly related to the mechanism of Injury."

opined as follows: (1) There was no such thing as a psychological diagnosis. (2) The psychiatric diagnoses included postpartum depression, bipolar disorder type unspecified and rule out some type of anxiety disorder. (3) In reasonable medically probability, the current psychiatric and psychological complaints would not be a direct result of injury. (4) Stepping off of a ladder was not a mechanism of injury that produced psychiatric illness. (5) Medical records were consistent with longstanding degenerative arthritis of the knee which appeared to be temporarily exacerbated. (6) The patient had been on longstanding psychiatric treatment receiving multiple psychiatric medications. (7) There was no chief complaint relative to any specific conditions. (8) The behavioral evaluation was non-consistent. (9) A psychological pain disorder was diagnosed by an examiner who had no medical training (LPC). Grade 4 degenerative joint disease (DJD) of the knee was typically a physically painful condition. (10) Therefore any pain disorder would be an axis III diagnosis and not an axis I psychiatric or psychological condition. (11) Independent neuropsychiatric/pain medicine examination with objective measures was recommended if this report was insufficient for administrative purposes.

Per utilization review dated October 3, 2012, the request for individual psychotherapy once per week for six weeks was denied based on the following rationale: *"Based on the clinical information provided, the request for individual psychotherapy 1 x week x 6 weeks is not recommended as medically necessary. The patient reports that she has undergone long-term psychiatric treatment for PTSD, bipolar, ADD, and panic disorder. Per peer review dated October 1, 2012, in reasonable medical probability, current psychiatric and psychological complaints would not be a direct result of the March 24, 2012, injury. Stepping off a ladder is not a mechanism of injury that produces psychiatric illness. The claimant has been in, what appears to be, long-standing psychiatric treatment receiving multiple psychiatric medications. There is no chief complaint relative to any psychiatric conditions. The evaluation is not independent and a psychological pain disorder is diagnosed by an examiner who has no medical training (LPC). There appears to be a relatedness issue which should be addressed on an administrative level prior to treatment authorization."*

On October 17, 2012, responded that did not call back to do a peer to peer and secondly the evaluator was a chiropractor and not a psychologist who had the adequate training to understand how they derived their pain disorder diagnosis for individual psychotherapy.

Per the reconsideration review dated October 26, 2012, the appeal for reconsideration for individual psychotherapy once per week for six weeks was denied based on the following rationale: *"Based on the clinical information provided, the request for individual psychotherapy 1 x week x 6 weeks is not recommended as medically necessary. Initial request for individual psychotherapy 1 x 6 was non-certified on October 3, 2012, noting that the patient reports that she has undergone long-term psychiatric treatment for PTSD, bipolar, ADD and pain disorder. Per peer review dated October 1, 2012, in reasonable medical probability, current psychiatric and psychological complaints would not be a direct result of the injury. Stepping off a ladder is not a mechanism of injury that produces psychiatric illness. The claimant has been in, what appears to be, long-standing psychiatric treatment receiving multiple psychiatric medications. There is no chief complaint relative to any psychiatric conditions. The evaluation is not independent and a psychological pain disorder is diagnosed by an examiner who has no medical training (LPC). There appears to be a relatedness issue which should be addressed on an administrative level prior to treatment authorization. There is no additional clinical information submitted for review to support a change in determination, and the previous non-certification is upheld."*

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

The patient reported that she has undergone long-term psychiatric treatment for PTSD, bipolar, ADD and pain disorder. Initial Behavioral Assessment from 9/09/12 was reviewed. There is no appropriate documentation available that justifies the patient's diagnosis as being causally related to or causing her personality disorder. A personality disorder is a pervasive form of mental illness which is pre-existing by definition, and which leads to claims of distress or impairment even if an occupational injury does not occur, according to the ODG. The patient has a pre-existing personality disorder, thus, the previous non-certification of the request for psychotherapy 1 x per week times 6 weeks is upheld.

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

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