

Medical Treatment Guidelines

Washington State Department of Labor and Industries

Psychiatric Conditions

Treatment may be authorized for psychiatric conditions caused or aggravated by an industrial condition for State Fund or Self-Insured workers' compensation claims. Treatment may also be temporarily authorized for unrelated psychiatric conditions that are retarding recovery of an allowed industrial condition. However, unrelated conditions are NOT the responsibility of the insurer. The insurer will stop payment for temporary treatment of unrelated conditions when:

- The allowed industrial condition is resolved, or
- The allowed industrial condition is no longer delayed from recovery by the unrelated psychiatric condition(s).

Psychiatric treatment must be provided in an "intensive" manner, which the department defines as at least 10-12 treatments in a 90-day authorization period. Prior authorization is required for both an initial psychiatric evaluation and for continued treatment.

A psychiatrist, a psychiatric advanced registered nurse practitioner (ARNP) or a licensed clinical PhD psychologist must provide all psychiatric treatment. In this document, the term "psychiatric provider" refers to the psychiatrist, psychiatric ARNP, or clinical PhD psychologist. A psychiatrist or psychiatric ARNP may be the attending provider and certify time loss compensation if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability. A psychiatric ARNP may not rate permanent partial disability or perform an independent medical examination (IME). A psychologist cannot be the attending provider and may not certify time loss compensation, sign the Report of Accident or rate permanent partial disability.

The psychiatric provider must submit a goal-directed treatment plan and reports that contain a summary of subjective complaints, objective observations, assessment toward meeting measurable goals, an updated intensive goal-directed treatment plan, and include the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV or current edition) axis format assessment.

Psychiatric providers treating psychiatric conditions allowed on a claim need to submit progress reports to the claim manager and to the attending provider every sixty days (WAC 296-21-270). If temporary treatment has been authorized for an unrelated psychiatric condition, progress reports need to be submitted to the claim manager and attending provider every thirty days (WAC 296-20-055).

Purpose of the Guideline

This guideline will assist psychiatric providers who treat injured workers for psychiatric conditions that are either the direct result of an industrial injury or are unrelated but retarding recovery from an industrial injury. This guideline may also be useful to physicians who treat injured workers' physical conditions, but who from time to time refer injured workers to psychiatric providers for treatment of psychiatric conditions. The guideline's usefulness in each of these settings is in part because the documentation described in the guideline will allow claim

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managers to validate their decisions, and thus helps to ensure efficient medical management of the claim.

The presence of pre-existing psychiatric conditions may delay or prevent recovery from industrial injuries. In many instances, treatment of such conditions is NOT the responsibility of the insurer. However, to assist an employee in recovering from an industrial injury or disease, the insurer may elect to pay for some level of treatment of such a condition, until the accepted claim condition is “fixed and stable”, i.e., reached maximum medical improvement, or no longer delayed from recovery by the unrelated condition.

Insurance companies often distinguish between industrial injuries and occupational diseases. Though the distinction can have substantial consequences in any given claim, for simplicity this guideline will use the term “industrial injury” to refer to both industrial injuries and occupational diseases.

Authorization Requirements

Initial psychiatric evaluation and ongoing treatment of a psychiatric condition both require prior approval from the insurer (WAC 296-21-270). Authorization for psychiatric treatment may be granted for periods of 90 days or less. Subsequent authorization periods of 90 days or less are contingent on documented progress in psychiatric treatment.

Claim managers may authorize payment for treatment of psychiatric conditions that are retarding recovery from an industrial injury, even though the injury did not cause the psychiatric condition, or aggravate a pre-existing psychiatric condition. Claim managers can also authorize payment for treatment of psychiatric conditions when they have been caused or aggravated by an industrial injury.

If authorization for psychiatric treatment is requested following an initial psychiatric evaluation, the claim manager will make a determination as to the relationship between the industrial injury and the psychiatric condition based on the information provided. For this reason, it is very important for the psychiatric provider to clearly indicate his or her opinion, and the basis for the opinion, and whether the worker’s psychiatric condition:

- Was not caused or aggravated by the industrial injury, but it creates a barrier to recovery from a condition for which the department has accepted liability.
- Was caused by the industrial injury.
- Is a pre-existing condition that was aggravated by the industrial injury. or
- Was neither caused nor aggravated by the industrial injury, nor is it creating a barrier to recovery from a condition for which the insurer has accepted liability.

Elements of a Comprehensive Psychiatric Plan

Psychiatric providers must include the following elements in a comprehensive psychiatric plan: formulation of a psychiatric diagnosis; identification of barriers to recovery; development of an intensive, goal-directed plan; and recommendation for duration of therapy. For psychiatrists and

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psychiatric ARNPs, the treatment plan may include prescribing medications. The psychiatrist or psychiatric ARNP may prescribe medication either as the attending provider or when providing concurrent care (See WAC 296-20-071 “Concurrent Treatment and WAC 296-21-270 “Psychiatric Services”).

Diagnosis of a Psychiatric Condition

Diagnosis is an essential first step to the development of a plan for treatment of psychiatric conditions. Diagnoses should be specific, and should use the nomenclature and numerical identification of the DSM-IV (or current edition). The diagnostic section of the initial report, and all subsequent reports, should address all five axes described in the DSM-IV (or current edition). Diagnoses should be based on all relevant historical information. Specific inquiry should be made into the worker’s pre-injury and current medical, psychosocial, and psychological status. Whenever possible, prior medical records should be reviewed to screen for the presence of diagnostically important information, and for information that may be useful in the creation of a treatment plan. Carefully document any pertinent positive or negative historical information.

Consideration should be given to the use of standardized measuring tools, such as the Rollins® or Beck® scales, and the use of individualized visual analog scales. Such measurements provide both support for diagnoses and benchmarks against which progress in treatment can be measured.

Identification of Barriers to Recovery from an Industrial Injury

Each diagnosed psychiatric condition should be assessed to determine whether it is retarding a patient’s recovery from an industrial injury. Any such barriers should be clearly identified and the report should provide an explanation that links the psychiatric condition to an observable, measurable behavior that interferes with recovery from an industrial injury.

- Example: Diagnosis: Depression, Major, Single episode (296.2)
 Barriers created by condition:
1. Insomnia: Patient is only able to sleep 2- 3 hours at a time and his sleep is fitful;
 2. Fatigue: Patient has no energy, and feels too tired to participate in reconditioning program;
 3. Despondency: Patient does not believe he will ever again be able to return to productive employment;
 4. Maladaptive personality trait expression: Patient expresses anger towards employer, which is exacerbated by chronic lack of sleep, fatigue and despondency.

Specific inquiry should be made to determine whether there are employment-related risk factors that should be addressed in a health care setting. For example, anger towards the employer, supervisor or coworkers may need to be addressed. Economic disincentives and employment-related loss of self-esteem can each contribute to the failure of a worker to make expected progress in recovery. Feelings of victimization may delay a return to a normal lifestyle.

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Such risk factors should be carefully identified and documented. Additional risk factors are discussed in the Attending Doctor's Handbook; "Helping Patients Return to Work", in the "Screening Checklist for Possible Risk Factors". Additional copies of the Attending Doctor's Handbooks are available without charge from the Department of Labor and Industries.

Formulation of a Psychiatric Treatment Plan

The psychiatric provider evaluating a worker with a psychiatric condition should create a treatment plan that addresses each diagnosed psychiatric condition and any identified barriers to recovery. The treatment plan must include intensive, goal-directed treatment and include a recommended duration of treatment. The treatment plan should be included in the evaluation report and updated throughout treatment.

Objectively determinable measurements of recovery should be identified for each condition for which treatment is proposed. Objective measurements should be individualized so that each worker's progress or lack of progress will be accurately assessed. Examples of such measurements include documentation of the level of physical activity; improved participation in physical therapy, occupational therapy, work hardening, or vocational counseling programs; normalization of common behavior patterns such as sleep cycles and eating disorders; and changes in medication usage. To the extent that a treatment plan may recommend medications, the plan should include a discussion of any predictable drug interactions the recommended medications might have with medications the worker is currently taking.

Example: Diagnosis: Depression, Major, Single episode (296.2)
 Plan: 1. Intensive Psychotherapy: Weekly for 12 weeks;
 2. Antidepressants: Sinequan® 50mg qhs, then increase as
 needed. No anticipated interaction with patient's current regimen
 of Motrin® and acetaminophen.

Identification of the measured variable should include a description of what will be measured, the intervals and duration during which the variable will be measured, the anticipated endpoint, and the anticipated progress to that endpoint at each interval measurement. When appropriate, use standardized measurements such as the Rollins® or Beck® scales to document the extent of recovery. Each variable to be measured should be explained to the injured worker before treatment is actually commenced. If necessary, the patient should be instructed in how to complete diaries that document such variables as pain, activity, medication use, etc.

In the event that the psychiatric treatment plan includes measurements of indicators that are outside the practice of the psychiatric provider, prior arrangements to obtain such measurements should be made by the psychiatric provider with the attending provider. Such measurements should be available to the psychiatric provider at the time each progress note is created.

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Example: Measurements arranged by the psychiatric provider and the attending provider:

The psychiatrist evaluating a knee injury patient includes monthly measurements of flexion and extension of the knee as two of the objective determinants of whether treatment is lowering barriers to the patient's recovery from a knee injury. The psychiatrist does not measure such parameters as part of his/her practice. At the time the psychiatrist creates the treatment plan, a check should be made with the attending provider to determine whether that medical provider can make monthly assessments of flexion and extension of the knee. Copies of the measurement results should be available to the psychiatric provider by the 15th of each of the next three months, for review when the injured worker is seen next.

Arrangements may be made with a physical therapist to provide such measurements. The psychiatrist summarizes the arrangement in the treatment plan.

Assessment of Psychiatric Treatment and Recommendations

A progress note should be prepared following each clinic visit. Per WAC 296-20-06101, legible copies of progress notes must be submitted to the department for all treatment. The progress note should document the worker's interval history, and should summarize any pertinent positive or negative findings. Indicators that are measured to assess progress should be documented along with measurements obtained during the interval period. An assessment should be made as to whether the measurements reflect the expected progress.

A visual analog scale can be a useful tool in assessing a worker's perception. Generally, such scales consist of a 10 cm horizontal line with words at opposite ends of the spectrum. Studies have shown that visual analog scales are most accurately representative of that which they seek to measure when the horizontal line contains no arbitrary divisions such as numbers, interval marks, etc. The worker is instructed to place a vertical mark at the point on the line that seems most appropriate to the worker.

Should expected progress not be made, the report of the psychiatric provider should contain a discussion concerning the postulated reasons for lack of progress. If necessary, the treatment plan should be reassessed, and any necessary modifications made.

The following is an example of a progress note that includes the goal-directed treatment plan along with an assessment of the injured worker's functioning. It is not necessary to include the goal-directed treatment plan in each progress report unless there have been changes in the treatment plan.

Example: Diagnosis: Depression, Major, single episode (296.2)

Measurements:

1. Physical Activity

- a. Goal: Within 60 day's patient will have returned to his or her pre-injury level of activity.
- b. Measurement: Patient will log hours of sleep and daily activities.
- c. Interval: Patient will complete log daily; logs will be reviewed weekly.

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- d. Mileposts: Week 1: Patient will sleep no more than 10 hours a day by the end of the week, and will document twenty minutes of activity, daily, by the end of the week. Week 2: Patient will sleep no more than 9 hours a day by the end of the week, and will have increased daily exercise to 30 minutes per day. Weeks 3 through 8: Sleep will not exceed 8 hours per day; patient will exercise at least 1 hour daily.
2. Communication
 - a. Goal: Decrease or eliminate anger-related return to work barriers.
 - b. Measurement: Patient response to scenarios that currently cause the patient to become angry and poorly communicative.
 - c. Interval: Will be assessed at each counseling session.
 - d. Mileposts: By week 4, patient will be able to verbalize the reasons for his anger. By week 8, patient will be able to remain appropriately communicative in employment situations that currently evoke angry outbursts.
 3. Return to Work
 - a. Goal: Within 90 days patient will return to work full time.
 - b. Measurement: Patient completes gradual return to work plan.
 - c. Interval: Patient's progress will be assessed monthly.
 - d. Mileposts: Month 1: By the end of the first month of treatment, patient will have returned to work part time 4 hours a day with restricted duties. Month 2: By the end of the second month of treatment, patient will have returned to work part time 6 hours a day and assumed normal duties. Month 3: By the end of the third month of treatment, patient will have return to work full time.

Assessment

Since the last visit, the patient has returned to light duty 4 hours a day. He or she reports an improvement in sleep with the increase in the dose of the antidepressant; and now feels rested after 8 hours of sleep. The patient is now exercising one hour a day, and is participating in household activities such as cutting the lawn with a power mower. The patient reports that on weekends the patient and spouse/partner walk their dog for about one hour each day. The patient has met the physical activity and vocational rehabilitation goals for this period.

What are the Reporting Requirements?

All reports should be written in a legible style that can be understood by non-medical personnel. Each report must contain at least a summary of subjective complaints, objective observations, medications prescribed by the psychiatrist or psychiatric ARNP, assessment of progress toward meeting goals, updated treatment plan, and DSM-IV (or current edition) axis format assessment (WAC 296-21-270). The use of specific examples of a worker's behavior may be a helpful way to communicate the effects of a psychological condition, or the effects of treatment for such a condition.

Providers treating psychiatric conditions allowed on a claim are required to submit progress reports to the claim manager and attending provider every sixty days (WAC 296-21-270). If

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temporary treatment has been authorized for an unrelated psychiatric condition, progress reports are required to be submitted to the claim manager and attending provider every thirty days (WAC 296-20-055).

What are the Billing Codes?

Complete information on billing codes may be found in the Medical Aid Rules and Fee Schedules, Professional Services, Psychiatric Services section or <http://feeschedules.Lni.wa.gov/>.