

Case Number:	CM13-0034491		
Date Assigned:	12/11/2013	Date of Injury:	11/26/2008
Decision Date:	02/07/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	10/15/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Psychiatry and Neurology, has a subspecialty in Geropsychiatry Addiction Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Records reviewed include 163 pages of administrative and medical records. The claimant is a 63 year old female whose date of injury is 11/26/2008. It is unclear what the nature of her original injury is. She carries the diagnosis of depressive disorder not otherwise specified (311). A peer review report of 9/23/13 shows the following course: In 10/2011 the claimant was diagnosed with major depressive disorder single episode, with pain and disability due to orthopedic injuries. It was noted that she remained in need of continued psychotherapy and visits with the psychiatrist for prescribing/monitoring of her psychotropic medications, and that the frequency of her psychotherapy visits needs to be left to the discretion of her therapist. In 12/07/12 she reports pain and difficulties with sleep; she is sad, anxious and appears tired. Two individual psychotherapy sessions per month is noted in the treatment plan. In 01/25/13 she is anxious, tired, socially isolative, irritable, sad, anxious, and apprehensive. Two individual psychotherapy sessions per month are requested. In 02/21/13 a note from [REDACTED] notes that her grooming and hygiene are fair, she is engaging, and there are no abnormalities in mental status. She is on Wellbutrin XL 300mg, Risperidone 1mg, Remeron 30mg, and lorazepam 1mg. There are no significant changes until 07/26/13 when the claimant reports improvement in anxiety and sleep with medications. She continues to be anxious, nervous, and apprehensive, worrying about the future and her physical limitations. Continued individual therapy two sessions per month for 6 months is noted in the treatment plan along with a follow up visit in 45 days. On 08/05/13 a primary treating physician's progress report notes her conditions of carpal tunnel syndrome, sprain and strain of the cervical spine and cervical spondylosis. There is a teleconference note showing that the claimant remained anxious and depressed with panic symptomatology manifested by

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Individual Psychotherapy; 2 sessions per month for 6 months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines for Mental Illness and Stress regarding Cognitive therapy for depression

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Cognitive Behavioral Therapy.

Decision rationale: The claimant has met the ODG standard recommendation of 13-20 psychotherapy sessions over 7-20 weeks. In this case there is no evidence presented of symptomatic improvement in her state of depression, irritability, anxiousness, and avoidance. As such there is no clear further indication for maintenance psychotherapy in this case. The request for ongoing individual psychotherapy 2 times per month for the next 6 months is denied. CA-MTUS does not address individual psychotherapy/cognitive behavioral therapy related to depression, therefore ODG was utilized in this decision. Recommended. Cognitive behavior therapy for depression is recommended based on meta-analyses that compare its use with pharmaceuticals. Cognitive behavior therapy fared as well as antidepressant medication with severely depressed outpatients in four major comparisons. Effects may be longer lasting (80% relapse rate with antidepressants versus 25% with psychotherapy). (Paykel, 2006) (Bockting, 2006) (DeRubeis, 1999) (Goldapple, 2004) It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996. (Gloaguen, 1998) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone. (Thase, 1997) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy. (Corey-Lisle, 2004) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. In longer therapies, the addition of psychotherapy helps to keep patients in treatment. (Pampallona, 2004) For panic disorder, cognitive behavior therapy is more effective and more cost-effective than medication. (Royal Australian, 2003) The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. The primary forms of psychotherapy that have been most studied through research are: Cognitive Behavioral Therapy and Interpersonal Therapy. (Warren, 2005) Delivering cognitive behavioral therapy (CBT) by telephone is as effective as delivering it face-to-face in the short term and telephone therapy is safe and has a higher patient retention rate. The attrition rate from psychotherapy can exceed 50% due to time constraints, lack of available and accessible services, transportation problems, and cost. Significantly fewer participants receiving telephone CBT discontinued their therapy than did those receiving face-to-face CBT. Both treatment groups showed significant improvement in depression, and there were no significant treatment differences when measured at post treatment between telephone and face-to-face CBT. However, face-to-face CBT was

significantly superior to telephone CBT during the follow-up period. The RCT used 18 sessions of either telephone CBT or face-to-face CBT. (Mohr, 2012) Maintenance co

Pharmacologic management: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines for Mental Illness and Stress regarding Cognitive therapy for depression.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Cognitive Behavioral Therapy.

Decision rationale: CA-MTUS does not address pharmacologic visits except as they relate to pain management. Per ODG, evaluation and management visits are individualized based on the patient's clinical stability and reasonable physician judgment. In this case the patient has been stabilized on 2 antidepressant agents, Wellbutrin and Remeron. She is additionally taking a low dose benzodiazepine. There has been essentially no change in her pharmacological management of significance. As such no significant intensity of office visits is warranted. I will authorize 2 pharmacologic management visits over the ensuing 12 months. Per ODG: CA-MTUS does not address pharmacologic visits except as they relate to pain management, therefore ODG was utilized in this decision. ODG does not specifically address pharmacologic visits, therefore office visit guidelines were utilized in this decision: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payers for possible evaluation, however, payers should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office

Office visit: Upheld

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MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Cognitive Behavioral Therapy

Decision rationale: CA-MTUS does not address office visits except as they relate to pain management. Per ODG, evaluation and management visits are individualized based on the patient's clinical stability and reasonable physician judgment. In this case the patient has been stabilized on 2 antidepressant agents, Wellbutrin and Remeron. She is additionally taking a low dose benzodiazepine. There has been essentially no change in her pharmacological management of significance. As such no significant intensity of office visits is warranted. I will authorize 2 pharmacologic management visits over the ensuing 12 months. Therefore she does not require additional office visits. This request is denied. CA-MTUS does not address office visits except as they relate to pain management, therefore ODG was utilized in this decision. Per ODG: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payers for possible evaluation, however, payers should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Ch