

Case Number:	CM13-0050821		
Date Assigned:	12/27/2013	Date of Injury:	11/01/2007
Decision Date:	03/14/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	11/13/2013

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 by the American Board of Psychiatry and Neurology (ABPN), has a subspecialty in Child and Adolescent Psychiatry from ABPN and is licensed to practice in New York. 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:

This case involves a disabled 48 year-old male who sustained a work-related crush injury to both hands on November 1, 2007. Subsequently, the patient was diagnosed with both major depressive disorder and posttraumatic stress disorder. Following an initial psychological consultation on February 6, 2008, the patient has been treated with cognitive behavioral therapy. The patient has also received services from a psychiatrist. By August 2012, the patient was prescribed venlafaxine 150mg twice daily, trazodone 100 or 200mg nightly, lorazepam 1mg thrice daily as needed and zolpidem 10mg nightly as needed. On August 22, 2013, the trazodone prescription was not renewed while bupropion sustained release 150mg every morning was added. There is report of a previous prescription of amitriptyline 50-75mg nightly. Despite combined mental health services, the patient has not made much progress and reportedly continues to endure significantly impairing mood and anxiety symptomatology. Following a phone consultation on October 16, 2013, four of the requested seven sessions of every other week psychotherapy were certified while two psychotropic medication management sessions were certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

7 sessions of individual psychotherapy (every other week; every other month through 11/30/13): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, Cognitive Behavioral Therapy and Cognitive Therapy for PTSD (updated 11/18/13). American Psychiatric Association. (2010). Management of Post-traumatic Stress Working Group (2010).

Decision rationale: Psychotherapy is a first-line intervention for both posttraumatic stress disorder and major depressive disorder. CBT is recommended by Official Disability Guidelines (ODG) with an initial trial of six visits over six weeks. Per Medical Treatment Utilization Schedule (MTUS), an initial trial of 3-4 cognitive behavioral psychotherapy visits over two weeks, with evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks. CBT is also endorsed by the American Psychiatric Association: "Use of a depression-focused psychotherapy alone is recommended as an initial treatment choice for patients with mild to moderate major depressive disorder, with clinical evidence supporting the use of cognitive-behavioral therapy." The time-limited therapy "is generally found to have more prolonged effects than pharmacotherapy after cessation of active treatment... CBT [has] shown lasting benefits in maintaining remission." Additionally, trauma focused cognitive therapy is recommended by the Department of Defense - VA Clinical Practice guideline and ODG, which states the therapy is "very effective in the treatment of post-traumatic stress disorder." Although these treatment interventions are well-supported by relevant peer-reviewed literature and reference guidelines, the patient has exceeded treatment recommendations and has not demonstrated treatment gains over the past five years. Thus, it is reasonable to infer that the treatment as provided will not further improve the patient's condition.

Two sessions of medication management:

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Office Visits (updated 11/18/13). American Psychiatric Association, (2010). Management of Post-traumatic Stress Working Group (2010).

Decision rationale: Psychotropic medication management represents a trusted intervention in the treatment armamentarium for those afflicted with major depressive disorder and posttraumatic stress disorder. According to the APA Treatment Guideline, "Patients should be carefully and systematically monitored on a regular basis to assess their response to pharmacotherapy, identify the emergence of side effects and assess patient safety." Further, according to the American College of Occupational and Environmental Medicine, "Antidepressant or antipsychotic medication may be prescribed for major depression or psychosis; however, this is best done in conjunction with specialty referral." Although medication therapy office visits are commonly front-loaded in the acute phase of illness and less

often during maintenance, there is no evidence-based algorithm for frequency or duration of treatment. Per ODG, "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." Thus, medication management services provided by a psychiatrist are well within accepted practice standards and reasonably expected to improve the patient's condition and prevent a more serious illness. During the most recent psychiatry note, the two medication changes signified a suboptimal medication regimen. Further, the patient remained psychiatrically symptomatic. Thus, based on the documentation provided within the context of relevant peer reviewed literature and reference guidelines, two sessions of medication management are reasonable.