

Case Number:	CM14-0105137		
Date Assigned:	07/30/2014	Date of Injury:	10/06/2002
Decision Date:	08/29/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/08/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Licensed in Psychology, 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 expert 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:

The claimant is a 53 year-old female [REDACTED] with a date of injury of 10/6/02. The claimant sustained injury while working for [REDACTED]. The mechanism of injury was not found within the medical records submitted for review. In his PR-2 report dated 7/3/14, [REDACTED] diagnosed the claimant with: (1) A 3-4 mm posterior disc bulge at L2-3 and mild left and moderate right facet hypertrophy and diffuse anterior flattening of the dura. At L3-4 there is bilateral decompression without posterior disc bulge or central or lateral spinal stenosis per MRI 01-11-13. (2) The patient has impingement syndrome of the right shoulder, status post-arthroscopic decompression in Sept. 2012; (3) Musculoligamentous strain of the lumbar spine; (4) Internal derangement of the right knee, status post arthroscopic meniscectomy on 10-2-12; (5) Status post lumbar spine surgery with [REDACTED] on 12-5-10, with fusion; and (6) Status post-low back surgery with Mulvania in Dec. 2007. Additionally, the claimant has developed psychiatric symptoms secondary to her work-related orthopedic injuries. In their RFA dated 6/12/14, [REDACTED] and [REDACTED], diagnosed the claimant with: (1) Major depressive disorder, single episode; (2) Generalized anxiety disorder; (3) Female hypoactive sexual desire disorder; and (4) Insomnia. The claimant has been treated for her psychiatric symptoms with psychotropic medication management services, individual and group psychotherapy, and relaxation/hypnotherapy services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cognitive Behavioral Group Psychotherapy 6 sessions for 12 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23.

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 and Stress Chapter Cognitive therapy for depression 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 posttreatment 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) Psychotherapy visits are generally separate from physical therapy visits. ODG Psychotherapy Guidelines: Initial trial of 6 visits over 6 weeks With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions) Other Medical Treatment Guideline or Medical Evidence: The American Psychiatric Association Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2010) (pgs. 48-49 of 118) Group th

Decision rationale: The CA MTUS does not address the treatment of depression therefore, the Official Disability Guideline regarding the cognitive treatment of depression and the APA Practice Guideline for the Treatment of Patients with Major Depressive Disorder will be used as reference for this case. Based on the review of the medical records, the claimant has been receiving individual and group psychotherapy as well as participating in relaxation/hypnotherapy sessions with [REDACTED] and/or his colleagues for quite some time. Unfortunately, it is unclear when those services began and exactly how many sessions of each modality have been

completed to date. Additionally, the progress noted in the most recent "Requested Progress Report/Request for Treatment" is vague. It is indicated that the claimant as "made progress towards current treatment goals as evidenced by: the patient reports of improved mood with treatment, she feels better able to cope with stressors due to treatment, and she reports decreased death thoughts due to her participation in treatment." None of these reported improvements are objective or measurable and are simply subjective reports. Additionally, it is unclear as to what treatment seem to be of most benefit. It is recommended that future reports be more specific regarding treatment progress and outcomes. In addition, the treatment plan listed on all of the submitted reports consistently remains the same. Given the period of time of receiving services, it would be expected that the treatment plan would change to accommodate the claimant's response to treatment. Without more specific information as indicated, the need for additional services according to the cited guidelines, is unable to be fully determined. As a result, the request for "Cognitive Behavioral Group Psychotherapy 6 sessions for 12 weeks" is not medically necessary.

Relaxation Training/Hypnotherapy 6 sessions for 12 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Pain-Hypnosis.

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 and Stress Chapter Hypnosis Recommended as an option, as indicated below. Hypnosis is a therapeutic intervention that may be an effective adjunctive procedure in the treatment of Post-traumatic stress disorder (PTSD), and hypnosis may be used to alleviate PTSD symptoms, such as pain, anxiety, dissociation and nightmares, for which hypnosis has been successfully used. (VA/DoD, 2004) (Brom, 1989) (Sherman, 1998) In a study testing the effect of hypnosis on irritable bowel syndrome (IBS), it was found that the hypnosis was effective in reducing psychological distress and as a result, the IBS symptoms improved substantially, despite there being no measured physiological change. More testing should be done to measure the effect of hypnosis on stress reduction, with or without physical ailment, as preliminary results are positive. (Palsson, 2002) According to one meta analysis, hypnotherapy is highly effective for patients with refractory IBS, but definite efficacy of hypnosis in the treatment of IBS remain unclear (Gholamrezaei, 2006) Hypnosis is not a therapy per se, but an adjunct to psychodynamic, cognitive-behavioral, or other therapies, and has been shown to enhance significantly their efficacy for a variety of clinical conditions. In the specific context of post-traumatic symptomatology, hypnotic techniques have been used for the psychological treatment of shell shock, battle fatigue, traumatic neuroses, and more recently, PTSD, and dissociative symptomatology. Hypnosis is defined by the APA as "a procedure during which a health professional or researcher suggests that a client, patient, or subject experience changes in sensations, perceptions, thought, or behavior." The hypnotic context is generally established by an induction procedure. An induction procedure typically entails instructions to disregard extraneous concerns and focus on the experiences and behaviors that the therapist suggests or that may arise spontaneously. Most of the case studies that reported that hypnosis was useful in treating post-trauma disturbances following a variety of traumas lack methodological rigor, and

therefore strong conclusions about the efficacy of hypnosis to treat PTSD cannot be drawn. Various meta-analyses of studies on the treatment of anxiety, pain, and other conditions imply that hypnosis can substantially enhance the effectiveness of psychodynamic and CBTs; however, most of the literature on the use of hypnosis for PTSD is based on service and case studies. Hypnotic techniques have been reported to be effective for symptoms often associated with PTSD such as pain, anxiety and repetitive nightmares. (VA/DoD, 2004)Criteria for the use of Hypnosis:Providers: Hypnosis should only be used by credentialed health care professionals, who are properly trained in the clinical use of hypnosis and are working within the areas of their professional expertise.Indications: There ar

Decision rationale: The ACOEM guideline regarding relaxation techniques as well as the ODG on the use of hypnotherapy will be used as references for this case. Based on the review of the medical records, the claimant has been receiving individual and group psychotherapy as well as participating in relaxation/hypnotherapy sessions with [REDACTED] and/or his colleagues for quite some time. Unfortunately, it is unclear when those services began and exactly how many sessions of each modality have been completed to date. Additionally, the progress noted in the most recent "Requested Progress Report/Request for Treatment" is vague. It is indicated that the claimant as "made progress towards current treatment goals as evidenced by: the patient reports of improved mood with treatment, she feels better able to cope with stressors due to treatment, and she reports decreased death thoughts due to her participation in treatment." None of these reported improvements are objective or measurable and are simply subjective reports. Additionally, it is unclear as to what treatment seem to be of most benefit. It is recommended that future reports be more specific regarding treatment progress and outcomes. In addition, the treatment plan listed on all of the submitted reports consistently remains the same. Given the period of time of receiving services, it would be expected that the treatment plan would change to accommodate the claimant's response to treatment. Without more specific information as indicated, the need for additional services according to the cited guidelines, is unable to be fully determined. As a result, the request for "Relaxation Training/Hypnotherapy 6 sessions for 12 weeks" is not medically necessary.