

<b>Case Number:</b>	CM14-0107089		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	01/13/2006
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2014

### 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 a Licensed Psychologist 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 51 year-old female (██████████) with a date of injury of 1/13/06. The claimant sustained injury to her back while working for the ██████████. The mechanism of injury was not found within the medical records. In the "Visit Note" dated 3/28/14, The claimant was diagnosed with, (1) Cervical radiculopathy; (2) Lumbar radiculopathy; (3) Right shoulder pain; (4) Fibromyalgia; (5) Osteoarthritis of the right hip; (6) Myositis/Myalgia; (7) Anxiety; (8) Depression; (9) Gastritis; (10) Hypertension; (11) Medication related dyspepsia; (12) Chronic nausea and vomiting; (13) NSAID intolerance; (14) GI bleeding; (15) History of failed opiates; and (16) Right shoulder pain secondary to fall. It is also reported that the claimant has developed psychiatric symptoms secondary to her work-related orthopedic injuries. In the most recent PR-2 report submitted for review dated 3/31/14, treating therapist, ██████████, and ██████████ diagnosed the claimant with: (1) Major depressive disorder, single episode; (2) Psychological factors affecting medical condition; and (3) Insomnia-type sleep disorder due to pain. The claimant has been receiving both psychological services and medication management services to treat her psychiatric symptoms. She has also been hospitalized and has attended an intensive outpatient program. The claimant's psychiatric diagnoses are the most relevant to this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Individual psychotherapy treatment once a week for twenty weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, behavioral interventions section.

**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: APA PRACTICE GUIDELINE FOR THE Treatment of Patients With Major Depressive Disorder Third Edition (2010) Maintenance phase (pg. 19) In order to reduce the r

**Decision rationale:** The California MTUS does not address the treatment of depression therefore, the Official Disability Guideline regarding the cognitive treatment of depression as well as the APA Practice Guideline for the Treatment of Patients with Major Depressive Disorder will be used as references for this case. Based on the review of the medical records, the claimant has been receiving psychological services for some time. The exact number of services is unknown. It is unknown when she began services with [REDACTED] and his colleagues as this information were not found within the submitted records. It does appear that the claimant

received services in 2013 and was hospitalized due to an exacerbation in her depressive symptoms. Following her hospitalization the injured worker was referred to the intensive outpatient program at [REDACTED]. However, she did not begin it until January 27, 2014 due to awaiting authorization. The claimant attended 2-3 days (3 groups per day) from January 27, 2014 through February 25, 2014 (per records). It appears that she resumed individual services with [REDACTED] in February. In the 2/28/14 PR-2 report, it is indicated that the claimant's "mood is stabilized" however, "treatment is imperative to help prevent decompensation and to help her move forward and deal with feelings." Although maintenance therapy appears necessary, the request for an additional 20 sessions once per week is excessive given the high utilization of services in the recent past. Given the lack of information about previous services and the number of sessions that were requested, the request for Individual psychotherapy treatment one session for twenty weeks is not medically necessary.