

<b>Case Number:</b>	CM14-0108382		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	05/01/2012
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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 Board Certified 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 (██████████) with a date of injury of 5/1/12. The claimant sustained injury to her back when she slipped and fell while on a step stool while working as a housekeeper for ██████████. In her PR-2 report dated 7/1/14, chiropractor, ██████████, diagnosed the claimant with: (1) Status post lumbar spine fusion; and (2) Chronic myofascial pain syndrome. It is also reported that the claimant has developed psychiatric symptoms secondary to her work-related orthopedic injuries. In her "Secondary Treating Physician's Progress Report" dated 6/20/14, ██████████ diagnosed the claimant with: Major depressive disorder, moderate to severe, secondary to fibromyalgia/physical pain/impairment. Additionally, in his "Initial Comprehensive Medi-Legal Psychological Report ML-104", dated 5/10/14, ██████████ diagnosed the claimant with: (1) Major depressive disorder, single episode, moderate to severe secondary to chronic pain; (2) Pain disorder associated with both psychological factors and a general medical condition - chronic, industrial; (3) Sleep disorder, insomnia type. The claimant has received psychotherapy services to treat her psychiatric symptoms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cognitive behavior therapy 10 sessions twice monthly:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral intervention 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).

**Decision rationale:** The CA MTUS does not address the treatment of depression therefore, the Official Disability Guideline regarding the cognitive treatment of depression will be used as reference for this case. Based on the review of the medical records, the claimant continues to experience chronic pain as well as symptoms of depression. It appears that the claimant has been treating with [REDACTED] since February 2014 for a unknown number of sessions. The request under review is being requested from [REDACTED] following his "Initial Comprehensive Medi-Legal Psychological Report ML-104" dated 5/10/14. Although the claimant is reported to be motivated for treatment, without knowing how many sessions have been completed to date the request for continued sessions cannot be fully determined based on the cited guidelines. Additionally, the request is for a 5 month duration, which does not allow for a reasonable period of time for reassessment of progress, treatment plan goals, and/or interventions. As a result, the request for "Cognitive behavior therapy 10 sessions twice monthly" is not medically necessary.

