

Case Number:	CM14-0156876		
Date Assigned:	09/26/2014	Date of Injury:	04/20/1999
Decision Date:	10/27/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	09/25/2014

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 Psychiatry & Neurology, Addiction Medicine, has a subspecialty in Geriatric Psychiatry 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:

Records reviewed include 70 pages of medical and administrative records. The injured worker is a 47 year old male whose date of injury is 04/20/1999, in which the patient fell 20 feet resulting in right multiple lower extremity surgeries. He was treated with pain management, epidurals, and underwent a spinal cord stimulator placement in 2004. He developed depression in 2001. His primary psychiatric diagnosis is major depressive disorder, moderate, with panic attacks. He had been provided with psychotherapy and medication management for chronic depression and anxiety, it is unclear from records what benefit he derived from this treatment in terms of improving his symptoms. An authorization request of 08/31/14 by ██████████ reported that the patient had developed extreme, profuse sweating which was evaluated by a general practitioner. The conclusion was that it was anxiety related. AME re-evaluation in psychiatry of 09/02/14 by ██████████ reported the patient began to work as a customer service representative in 01/2014 but found it stressful. He had a panic attack and was taken off work. He stopped his Klonopin and Wellbutrin, then restarted Lexapro and Ativan. He was receiving psychotherapy and medication management with ██████████. Current complaints include anxiety, rumination over his injury, nightmares, flashbacks, and avoidance behaviors related to heights. The AME indicated that the PTSD symptoms were missed by both ██████████ and ██████████ and the condition was therefore not diagnosed. Pain was 7-7.5/10. His antidepressants had been ineffective and it was felt to be due to the newly diagnosed PTSD, that they were not good choices (e.g. Wellbutrin). He described symptoms of depression including crying easily, feelings of worthlessness, lack of energy, decreased enjoyment; and moderate anxiety. BDI=40, BAI=37 consistent with mental status. He was diagnosed with major depressive disorder, chronic, moderately severe, and post-traumatic stress disorder, and psychotherapy was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychotherapy counseling approximately two to three times a month for a period of ten months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines, Mental Health Chapter

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 Therapy for PTSD.

Decision rationale: The patient was being treated with psychotherapy and continued in treatment for major depressive disorder with [REDACTED]. In the AME of 09/02/14 he described the classic symptoms of PTSD and was given that diagnosis. Given this development, the patient may benefit from a trial of trauma focused CBT targeted towards his PTSD symptoms. Non-trauma focused CBT, such as the treatment received previously, would not have reduced his PTSD symptoms. However, ODG recommends a trial of an initial 6 visits over 6 weeks, then with evidence of objective functional improvement progressing on to certification of additional sessions. This request, as written, is therefore not medically necessary. MTUS does not address psychotherapy for PTSD. ODG recommended. There is evidence that individual Trauma-focused cognitive behavioral therapy/exposure therapy (TFCBT), stress management and group TFCBT are very effective in the treatment of post-traumatic stress disorder (PTSD). Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There was some evidence that individual TFCBT is superior to stress management in the treatment of PTSD at between 2 and 5 months following treatment, and also that TFCBT was also more effective than other therapies. (Bisson, 2007) (Deville, 1999) (Foa, 1997) (Foa, 2006) Cognitive therapy is an effective intervention for recent-onset PTSD. (Ehlers, 2003) Empirical research has demonstrated consistently that Cognitive Behavioral Therapy (CBT) is supported for the treatment of PTSD. It has been demonstrated that CBT is more effective than self-help, debriefing, or supportive therapy in preventing more entrenched PTSD symptoms. Importantly, it is unclear if supportive therapy was of any clinical value in the treatment of PTSD since it appeared to impede psychological recovery. Strengths of CBT is difference in the safety and efficacy of providing treatment, working through traumatic memories, and helping the person through to re-frame one's interpretations of both the event and PTSD symptoms. Most importantly, CBT tended to have no to few side effects, unlike medications and could be employed efficiently for acute symptom treatment. (Warren, 2005) Cognitive Therapy (CT) is effective with civilian men and women exposed to combat and noncombat trauma. (VA/DoD, 2004) (Lovell, 2001) (Marks, 1998) CT is effective for women with PTSD associated with sexual assault. (Resick, 2002) Cognitive behavior programs, including exposure therapy, are currently the treatment of choice for PTSD. (Botella, 2009) The AHRQ study concluded that cognitive processing therapy has moderate evidence supporting efficacy for improving some outcomes for adults with PTSD, whereas the IOM report did not make a specific conclusion about cognitive processing therapy. Given the above the request is not medically necessary.

