

Case Number:	CM14-0190477		
Date Assigned:	11/21/2014	Date of Injury:	03/08/2002
Decision Date:	02/10/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/14/2014

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 injured worker is a 56 year-old male [REDACTED] with a date of injury of 3/8/2002. The injured worker sustained multiple bodily injuries including his scapula, shoulder, and back when a forklift rolled over him while he was working for [REDACTED]. The injured worker also developed psychiatric symptoms secondary to his work-related orthopedic injuries and chronic pain. He has been receiving medication management services from [REDACTED] as well as individual psychotherapy from [REDACTED]. In his "Psychotherapy Report" dated 9/30/14, [REDACTED] diagnosed the injured worker with: (1) Major depressive disorder, single episode, severe, without psychotic symptoms; and (2) Pain disorder associated with both psychological factors and a general medical condition. The request under review is for an additional 12 psychotherapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Psychotherapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive therapy for depression. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Psychotherapy, Mental Illness & Stress

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 post treatment 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 injured worker completed an initial psychological evaluation with [REDACTED] in October 2013 and has been participating in biweekly psychotherapy sessions since that time. It appears that the injured worker completed a total of 18 sessions between October 2013 through September 2014. The ODG recommends a total of up to 20 individual psychotherapy sessions for the cognitive treatment of depression. The request for an additional 12 sessions exceeds the cited guideline. As a result, the request for "12 Psychotherapy sessions" is not medically necessary.