

<b>Case Number:</b>	CM14-0191730		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	06/11/1999
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	10/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Psychiatrist 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 247 pages of medical and administrative records. The injured worker is a 54-year old male whose date of injury is 06/11/1999. The primary diagnosis is major depressive disorder single episode severe. He sustained an injury to his low back and right shoulder. Treatments included surgeries, physical therapy, and pain management. He developed insomnia and depression due to his disability and pain. Orthopedic diagnoses include lumbar disc disease, postlaminectomy syndrome in the lumbar spine, cervical disc disease, and right shoulder pain status post right shoulder arthroscopy. He has a long mental health history including multiple psychiatric re-evaluations. On 04/28/14 a psychological consultation was performed. The patient has been in psychotherapy since 2001, and saw a psychiatrist in the same office for psychotropic medications. When the psychiatrist retired 6 years ago his pain management physician, [REDACTED] prescribed for him. He has been taking Wellbutrin for five years and has been seeing a private psychiatrist, [REDACTED], for around one year through Medicare/MediCal. He reported depressed mood, loss of sexual interest, crying easily, hopelessness, social isolation, problems with memory/concentration, nervousness, and anger. Current medications include hydrocodone, Oxycontin, nortriptyline, omeprazole, Viagra, levothyroxine, bupropion, and tamsulosin. Medically he suffers from hypertension and hypothyroidism. He scored 35 on the Beck Depression Inventory (severe) and 25 on the Beck Anxiety Inventory (moderate to severe). On 10/27/14 he had low back pain with bilateral leg pain with numbness. On 11/04/14 [REDACTED] reported that the patient had pain of 5/10 and Norco was being weaned down. He denied depression, nervousness, mood swings, or sleep disturbance. On 12/02/14 the patient was essentially the same, pain was 4/10.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **26 PSYCHOTHERAPY VISITS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES

**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 depression.

**Decision rationale:** The patient has been in psychotherapy since 2001. It is unclear what objective functional improvement he has received. The last report of 11/04/14 by [REDACTED] showed that the patient denied depression, nervousness, mood swings, or sleep disturbance. It is unclear what further benefit the patient would derive from additional psychotherapy, and he has far exceeded guidelines for number of session's recommendation. This request is therefore noncertified. CA-MTUS references CBT in relation to chronic pain. ODG was used in the formulation of this decision as it relates to major depressive disorder. ODG recommends cognitive behavior therapy for depression: 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) Maintenance cognitive-behavioral therapy (CBT) to prevent recurrent depression is most effective in patients at highest risk for relapse, defined as those with 5 or more previous depressive episodes. For individuals at more

moderate risk for recurrence (fewer than 5 prior episodes), structured patient psychic education may be equally effective. High-risk patients in particular may benefit from specific elements of maintenance CBT by reducing cognitive vulnerability factors for recurrent depression, such as ruminating, negative attributions and memories, and dysfunctional beliefs, or by maintaining positive emotions when experiencing stress. (Stangier, 2013) Studies show that a 4 to 6 session trial should be sufficient to provide evidence of symptom improvement, but functioning and quality of life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. (Crits-Christoph, 2001) Subclinical depression: Psychotherapy may be effective in treating subclinical depression and may prevent progression to major depressive disorder (MDD), according to a meta-analysis. There has been recent controversy regarding the efficacy of psychotherapy in treating subclinical depression, and antidepressants and benzodiazepines are no better than placebo for treating this condition. The most common form of psychotherapy used was cognitive-behavioral therapy. Results showed that undergoing psychotherapy significantly reduced the incidence of MDD at the 6-month follow-up, with a relative risk (RR) of 0.61 vs the control groups. (Cuijpers, 2014). ODG Psychotherapy Guidelines: - Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made. Therefore, 26 Psychotherapy Visits is not medically necessary.

## **1 PSYCHIATRIC CONSULTATION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

**Decision rationale:** The patient has had multiple psychiatric re-evaluations and is seeing a private psychiatrist on Medicare and Medical, there is no further need for psychiatric evaluations at this time. This request is therefore noncertified. CA-MTUS does not address psychiatric evaluations. Per ACOEM, specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. Some mental illnesses are chronic conditions, so establishing a good working relationship with the patient may facilitate a referral or the return-to-work process. Treating specific psychiatric diagnoses are described in other practice guidelines and texts. It is recognized that primary care physicians and other non psychological specialists commonly deal with and try to treat psychiatric conditions. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. Therefore, 1 Psychiatric Consultation is not medically necessary.

## **6 MEDICATION MANAGEMENT VISITS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** The patient has been on Wellbutrin for 5 years. He has been receiving consultation and treatment by a private psychiatrist for around a year and prior to that as well. He sees [REDACTED] for medications. And per ACOEM can be effectively and safely managed by a primary care of occupational physician. He does not have a significant mental illness. Therefore this request is noncertified. CA-MTUS does not address psychiatric evaluations. Per ACOEM, specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. Some mental illnesses are chronic conditions, so establishing a good working relationship with the patient may facilitate a referral or the return-to-work process. Treating specific psychiatric diagnoses are described in other practice guidelines and texts. It is recognized that primary care physicians and other non psychological specialists commonly deal with and try to treat psychiatric conditions. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. Therefore, 6 Medication Management Visits is not medically necessary.