

<b>Case Number:</b>	CM15-0048207		
<b>Date Assigned:</b>	03/20/2015	<b>Date of Injury:</b>	07/31/2013
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California, Arizona, Maryland  
Certification(s)/Specialty: Psychiatry

### 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 was a 40 year old female, who sustained an industrial injury, July 31, 2013. The injured worker previously received the following treatments psychiatric session, Celexa and Wellbutrin. The injured worker was diagnosed with posttraumatic stress disorder and panic disorder without agoraphobia. According to progress note of February 22, 2015, the injured workers chief complaint of series of traumatic events/exposures during the course of the injured worker usual and customary duties. The injured worker was on psychiatric disability since July 31, 2013. The injured worker was not coping with symptoms that infrequently interfere with the daily functioning. The expressed symptoms of the injured worker were depressed mood, hypervigilance, difficulties sleeping, intrusive thoughts that significantly affect the level of anxiety. The injured worker reported increase in symptoms of anxiety and panic attacks since the last visit. The treatment plan included additional psychotherapy for cognitive behavioral therapy 6 visits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Psychotherapy-Additional Cognitive Behavioral Therapy (Cope) With EMDR Times Six  
Quantity: 6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & stress, Eye movement desensitization & reprocessing (EMDR).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Mental Illness and Stress Topic: Cognitive therapy for PTSD.

**Decision rationale:** ODG states "Cognitive therapy for PTSD is 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 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, de-briefing, 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. Number of psychotherapy sessions: There is very limited study of the exact number of sessions needed in a course of psychological or psychiatric treatment. There are a small number of studies offering some basic directions on this topic, and they are summarized below. Using historical data from workers' compensation cases, the ODG guidelines for number of visits are consistent with actual reported data. Using the ODG Crosswalk for the common ICD9 diagnosis code 308, Acute reaction to stress, and the CPT procedure code 90806, Individual psychotherapy, office or outpatient, approximately 45-50 minutes face-to-face, the number of visits at the 25% percentile was 5, the median was 12 visits, and the 75% outlier percentile was 33. (URA, 2014) This meta analysis found that the effects increased somewhat with a higher number of treatment sessions beyond 4 to 6 sessions, but this did not continue after 18 to 24 total sessions. However, there was a strong relationship between the number of treatment sessions per week and effect size. When two instead of one treatment session are given per week, without increasing the total number of sessions, the effect size increases by 0.45. (Cuijpers, 2013) This systematic review compared 12 to 20 sessions with abbreviated psychotherapy protocols (8 sessions), and they concluded that depression can be efficaciously treated with either protocol. (Nieuwsma, 2012) The benefit to the patient of a trial is that, if likely treatment failures can be identified early in the treatment process, alternative treatment strategies can be pursued. Nonresponse by session/week four was strongly associated with nonresponse at the end of treatment. This systematic review focused solely on symptom-based outcome measures, because functioning and quality of life indices do not change as markedly within a short duration of psychotherapy. (Crits-Christoph, 2001) This study showed early rapid response after 5 psychotherapy sessions, but complete response after 20 sessions. (Hayes, 2007) This study suggested that adolescents who have not demonstrated at least a 16% reduction in their depressive symptoms after 4 sessions should consider a change in the treatment plan. (Gunlicks-Stoessel, 2011) Psychotherapy lasting for at least a year, or 50 sessions, is more effective than shorter-term psychotherapy for patients with complex mental

disorders, according to a meta-analysis of 23 trials. Although short-term psychotherapy is effective for most individuals experiencing acute distress, short-term treatments are insufficient for many patients with multiple or chronic mental disorders or personality disorders. (Leichsenring, 2008) Many patients show remission of symptoms in 8-12 sessions, but a full course of treatment is considered to be 14-16 sessions although severe cases can take longer. (Butler, 1995) A range of 11-16 treatment sessions is suggested for short-term treatment of depression. (Ward, 2000) Long-term psychotherapy (30 sessions or more) is more effective than short-term therapy, particularly in cases of more severe psychiatric impairment. (Leichsenring, 2001) Clearly there is benefit in evaluating progress, but there is insufficient evidence to specify a specific number of visits for a trial, and there is risk that such a number could be used as a cap. Therefore, ODG recommends that at each visit the provider should look for evidence of symptom improvement, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate. 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. The injured worker has been diagnosed with posttraumatic stress disorder and panic disorder without agoraphobia and has undergone at least 35 psychotherapy sessions with no evidence of any objective functional improvement. She continues to experience symptoms such as depressed mood, hypervigilance, difficulties sleeping, intrusive thoughts that significantly affect the level of anxiety and has reported increase in symptoms of anxiety and panic attacks. There is no clinical indication for further treatment since she has not had any improvement with prior treatment. Thus, the request for Psychotherapy-Additional Cognitive Behavioral Therapy (Cope) With EMDR Times Six Quantity: 6 is excessive and not medically necessary.