

Case Number:	CM14-0122095		
Date Assigned:	08/06/2014	Date of Injury:	04/10/2012
Decision Date:	10/08/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	08/01/2014

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 claimant is a 54 year-old male [REDACTED] with a date of injury of 4/10/14. The claimant sustained injury while working for [REDACTED], Inc. The mechanism of injury nor the injured body parts were found within the medical records submitted for review. It is assumed that the claimant developed psychiatric symptoms secondary to his work-related injury as he has been treating with [REDACTED] and [REDACTED]. In his 5/31/14 PR-2 report, [REDACTED] diagnosed the claimant with Adjustment disorder with mixed anxiety and depression. However, in his RFA dated 5/31/14, [REDACTED] diagnosed the claimant with Major depressive disorder, single episode, severe. Other than [REDACTED] two records, it is noted that there were no other psychiatric/psychological medical records submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twenty (20) sessions of individual psychotherapy between 4/30/2014 and 8/21/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: Based on the review of the limited medical records, the claimant has been receiving psychotropic medication management services from [REDACTED] and psychotherapy from [REDACTED]. The number of completed psychotherapy sessions to date is unknown as is the claimant's response to those sessions as there were no psychotherapy progress notes or reports included for review. Without sufficient information, the need for additional therapy sessions cannot be fully determined. As a result, the request for "Twenty (20) sessions of individual psychotherapy between 4/30/2014 and 8/21/2014" is not medically necessary.