

<b>Case Number:</b>	CM14-0125233		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	10/12/2007
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	07/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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 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 49 year-old female (██████████) with a date of injury of 10/12/07. The claimant sustained injury to her back while working for ██████████, Inc. The mechanism of injury was not found within the records. In his PR-2 report dated 7/9/14, ██████████ diagnosed the claimant with: (1) Lumbago; (2) Thoracic/lumbosacral neuritis/radiculitis, unspecified; (2) Postlaminectomy syndrome lumbar region; (4) Intervertebral lumbar disc disorder without myelopathy lumbar region; and (5) disc disease, lumbar. She has been treated for her orthopedic injuries using medications, physical therapy, chiropractic, and surgery. It is also reported that the claimant developed psychiatric symptoms secondary to her work-related orthopedic injury and pain. In his PR-2 report dated 7/11/14, ██████████ diagnosed the claimant with: (1) Major depressive disorder, recurrent, severe; (2) Pain disorder associated with psych factors; and (3) Avoidant personality. This diagnosis is further supported by treating psychiatrist, ██████████. She has been receiving psychotropic medications with medication management in addition to psychotherapy to treat her psychiatric symptoms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Psychotherapy visits x 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 (Cognitive Behavioral Therapy) guidelines for chronic pain

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: APA Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition (2010), Maintenance phase (pg. 19)

**Decision rationale:** 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) Based on the review of the medical records, the claimant was initially evaluated by ██████████ in January 2013 and began receiving follow-up psychotherapy services. According to the utilization review determination letter dated 7/28/14, the claimant has completed a total of 35 psychotherapy sessions. However, the exact number of completed sessions cannot be confirmed from the medical records submitted. In the most recent PR-2 report from ██████████, the objective findings were listed as, "facial expression communicates obvious pain. Mood is depressed." There are truly no objective findings indicated. Additionally, the treatment plan indicates that the claimant will continue to receive weekly psychotherapy to "improve coping skills and less isolative/agoraphobic." There does not appear to be a change in treatment plan given the claimant's continued symptoms and lack of significant progress. The ODG indicates that for additional sessions to be indicated there needs to be "objective functional improvements." Additionally, the APA discusses the changes in treatment planning regarding the tapering of sessions during the maintenance phase of treatment. After this period of time of receiving services, there does not appear to have been a gradual tapering of sessions. Given this information and utilizing the guidelines, the request for additional "Psychotherapy visits x 6" is

not medically necessary.