

<b>Case Number:</b>	CM14-0173075		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	10/09/1993
<b>Decision Date:</b>	12/02/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 56 year-old male [REDACTED] with a date of injury of 10/9/93. The claimant sustained injury to his bilateral shoulders, left elbow, bilateral wrists and hands, and neck while working as a Correctional Officer for the [REDACTED]. It is also reported that the claimant has developed psychiatric symptoms secondary to his work related orthopedic injuries and chronic pain. In the PR-2 report dated 9/5/14, treating Psychologist, [REDACTED], diagnosed the claimant with: (1) Recurring depression; and (2) Psychogenic pain. In the narrative report dated 9/11/14, [REDACTED] also discusses the claimant's "PTSD-like symptoms" without offering an official diagnosis of PTSD.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Individual psychological therapy Quantity: 25:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 400-401. Decision based on Non-MTUS Citation Official Disability Guidelines Cognitive Behavioral Therapy (CBT)

**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) Cognitive therapy for panic disorder Recommended. The overwhelmingly effective psychotherapy treatment for Panic Disorder is Cognitive Behavioral Therapy (CBT). CBT produced rapid reduction in panic symptoms. Typically, CBT is provided over 12-14 sessions, conducted on a weekly basis. Each session lasts approximately 1 hour. CBT can be administered either as a stand-alone treatment or in conjunction with medication. For those individuals who don't respond to medication, CBT is likely to be the only viable treatment for panic symptoms. CBT individual therapy produced superior results over group CBT. (Warren, 2005) Cognitive therapy for PTSD 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 also that TFCBT was also more effective than other therapies. (Bisson, 2007) (Devilley).

**Decision rationale:** The CA MTUS does not address the treatment of depression therefore, the Official Disability Guidelines regarding the cognitive treatment of depression and PTSD as well as the AMA Practice Guideline for the Treatment of Patients with Major Depressive Disorder will be used as references for this case. Based on the review of the limited medical records included for review, the claimant has continued to experience chronic pain as well as psychiatric symptoms since his injury in October of 1993. In his most recent PR-2 report from September 2014, treating Psychologist, [REDACTED] recommended additional weekly psychotherapy. It is unclear from the records as to how many psychotherapy sessions have been completed in 2014 and the progress made from those sessions. Although the claimant received an award for future treatment, the request for an additional 25 psychotherapy sessions over roughly 6 months, appears excessive. The APA Practice Guideline recommends a decrease in services during the maintenance phase of treatment. Based on the guidelines, the request for additional "Individual psychological therapy Quantity: 25" is not medically necessary.