

Case Number:	CM15-0124802		
Date Assigned:	07/09/2015	Date of Injury:	09/23/2013
Decision Date:	08/12/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/29/2015

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 is a 54 year old male, who sustained an industrial injury on 9/23/13. The injured worker has complaints of headaches; blurred vision; right ear discomfort with tinnitus; positional vertigo; nightmares of his accident, which wake him up twice a week; feelings of claustrophobia and flashbacks of the accident. The documentation noted that the injured worker at the time of the injury sustained 3rd degree burns to his ears, face, upper mid back and right arm during the accident. The documentation noted that the injured workers thought process was clear and linear and there was no evidence of a thought disorder. The documentation noted that on the posttraumatic scale he had endorsed 15 symptoms, which resulted in a severe symptoms rating. The documentation noted that the nature of the posttraumatic stress disorder is chronic. The diagnoses have included post-traumatic stress disorder, chronic severe; cognitive disorder not otherwise specified and mood disorder, due to a general medical condition with depressive features. Treatment to date has included psychotherapy. The request was for individual psychotherapy, 18 sessions for chronic post-traumatic stress disorder; neuropsych cognitive remediation, 8 sessions and psycho testing by psychiatrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Individual psychotherapy, 18 sessions for chronic PTSD: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress.

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 also 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 non-response 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 in 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 post-traumatic stress disorder, chronic severe; cognitive disorder not otherwise specified and mood disorder, due to a general medical condition with depressive features. He has undergone psychotherapy treatment and has completed at least 10 sessions. The guidelines recommend up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. The request for individual psychotherapy, 18 sessions for chronic PTSD exceeds the guideline recommendations since he has already completed 10 sessions so far. It is to be noted that the UR physician authorized 10 more sessions of individual psychotherapy. The request is not medically necessary.

Neuropsych cognitive remediation, 8 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 397.

Decision rationale: AECOM guidelines state "Consider specialty referral if persistent symptoms are not consistent with clinical findings. In general, neuropsychological testing is not indicated early in the diagnostic evaluation. Rather, it is most useful in assessing functional status or determining workplace accommodations in individuals with stable cognitive deficits." The request for Neuropsych cognitive remediation, 8 sessions is not medically necessary since the injured worker is already being treated with individual psychotherapy for post-traumatic stress disorder, chronic severe; cognitive disorder not otherwise specified and mood disorder, due to a general medical condition with depressive features.

Psycho testing by psych/phys: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chicago, Author, page 398-399.

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: Psychological evaluations.

Decision rationale: ODG states, "Psychological evaluations are recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in subacute and chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI - Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory, (3) MBMD - Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 - Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 - Brief Battery for Health Improvement, (9) MPI - Multidimensional Pain Inventory, (10) P-3 - Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI-II - Beck Depression Inventory, (20) CES-D - Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale - VAS. (Bruns, 2001)" The request for psycho testing by psych/phys does not identify the type of psychological testing being requested or the clinical need for such type of testing. In the absence of the above information including the detailed information of the names of the psychological tests as well as the quantity being requested; the medical necessity cannot be established. Therefore, the request is not medically necessary.