

Case Number:	CM15-0092002		
Date Assigned:	05/18/2015	Date of Injury:	09/12/2012
Decision Date:	06/22/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	05/13/2015

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, Texas

Certification(s)/Specialty: Psychiatry, Geriatric Psychiatry, Addiction 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 34-year-old female whose date of injury is 09/12/2012. She reported developing psychiatric symptoms reportedly because of harassment by coworkers and a hostile work environment. She was diagnosed with depressive disorder, cannabis dependence, cannabis induced anxiety disorder with panic, pre-existing obsessive-compulsive disorder. A UR of 04/09/15 indicated that she had an office visit on 03/02/15. At that time, she was on Abilify and Lexapro. She suffered from migraines, GI distress, weight gain, decreased socialization, increased fatigue, anxiety attacks, and obsessive-compulsive behavior. There was an "unofficial report" that she had been psychiatrically hospitalized in 2013 for anxiety and suicidal ideation, and in 2014 for anxiety, OCD, visual hallucinations, and suicidal thoughts. She was diagnosed with major depressive disorder severe with anxiety. She had received four psychotherapy sessions but there was no documentation-showing efficacy, therefore further certification was not given.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 cognitive behavioral therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

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 & Stress, Cognitive therapy for depression.

Decision rationale: 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. 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 patient has the diagnosis of major depressive disorder. No current documentation was provided after 10/2014 to justify further services. She has received four psychotherapy sessions without documented evidence of objective functional improvement of her symptoms. This request is not medically necessary.