MEDICAL CONTESTED CASE HEARING NO. 15013

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that the Claimant is not entitled to six sessions of psychotherapy for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

A contested case hearing was held on December 1, 2014, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that the Claimant is not entitled to six sessions of psychotherapy for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by IN, ombudsman. Respondent/Carrier appeared and was represented by RG, attorney.

DISCUSSION

Claimant sustained a compensable injury on (Date of Injury), in a motor vehicle accident. On July 14, 2014, NP, M.D., Petitioner/Claimant's (Claimant) primary treating provider, requested preauthorization for an additional six sessions of psychotherapy for the diagnoses of Post Traumatic Stress Disorder (PTSD) and major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior. The preauthorization request went to a Utilization Review Agent (URA) reviewer who initially denied the request, and then the request was submitted for reconsideration by another URA reviewer, who also denied the request. The Claimant appealed the denials through an Independent Review Organization (IRO). The IRO reviewer upheld the previous denials, and Claimant appealed that determination by requesting a Medical Contested Case Hearing. It was Claimant's position the preponderance of the evidence was against the IRO determination and he should be entitled to six sessions of psychotherapy. It was the Respondent/Carrier's (Carrier) position that the IRO determination should be upheld.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based

medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308 (s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

The ODG provides the following guidelines concerning mental illness and stress.

> ODG Mental Illness and Stress – Cognitive therapy for depression
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> 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 major depressive disorder 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) Maintenance CBT to prevent recurrent depression is most effective in patients at highest risk for relapse, defined as those with 5 or more previous depressive episodes. For individuals at more moderate risk for recurrence (fewer than 5 episodes), structured patient psychoeducation may be equally effective. High-risk patients in particular may benefit from specific elements of maintenance CBT by reducing cognitive vulnerability factors for recurrent depression, such as ruminating, negative attributions and memories, and dysfunctional beliefs, or by maintaining positive emotions when experiencing stress. (Stangier, 2013) Studies show that a 4 to 6 session trial should be sufficient to provide evidence of symptom improvement, but functioning and quality of life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. (Critis-Christoph, 2001). See Number of psychotherapy sessions for more information. See also Bibliotherapy; Computer-assisted cognitive therapy. Pyschotherapy visits are generally separate from physical therapy visits.

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 IRO doctor, a medical doctor board certified in physical medicine and rehabilitation, thought the requested treatment was not medically necessary, noting Claimant received twenty-four sessions of psychotherapy in 2013 from which he did not show any improvement. The IRO doctor also observed that despite Claimant's report of worsening depression, his medical evaluation did not exhibit any specific abnormalities.

Claimant testified his previous psychotherapy sessions had slowly improved his symptoms, and his medical records did not accurately reflect his progression. Claimant further testified that he required the additional psychotherapy sessions in order for him to improve and return to work. Claimant also offered a letter dated August 26, 2014, from his treating provider, Dr. P, who indicated that Claimant requires further treatment for his depression and PTSD. However, neither Dr. P nor any other of Claimant's treating providers cited the ODG treatment guidelines or any other evidence-based medical evidence to support the medical necessity of the proposed treatment. Moreover, Dr. P did not rebut the IRO's finding that Claimant had not made progress following his prior psychotherapy sessions. As Claimant did not overcome the IRO determination by a preponderance of the evidence-based medical evidence, he has accordingly failed to meet his burden of proof.

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. The Texas Department of Insurance, Division of Workers' Compensation has jurisdiction to hear this matter.

   B. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   C. On (Date of Injury), Claimant was the employee of (Employer), Employer.

   D. On (Date of Injury), Employer provided workers' compensation insurance with Amerisure Mutual Insurance Company, Carrier.

   E. On (Date of Injury), Claimant sustained a compensable injury.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. The Independent Review Organization (IRO) determined Claimant is not entitled to six sessions of psychotherapy for the compensable injury of (Date of Injury).

4. The six psychotherapy sessions are not health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the IRO that the Claimant is not entitled to six sessions of psychotherapy for the compensable injury of (Date of Injury).

DECISION

The Claimant is not entitled to six sessions of psychotherapy for the compensable injury of (Date of Injury).

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with Section 408.021 of the Act.

The true corporate name of the insurance carrier is **AMERISURE MUTUAL INSURANCE COMPANY,** and the name and address of its registered agent for service of process is:

CORPORATION SERVICE COMPANY
211 EAST 7th STREET, SUITE 620
AUSTIN, TEXAS 78701

Signed this 2nd day of December, 2014.

Kara Squier
Hearing Officer