MEDICAL CONTESTED CASE HEARING NO. 16053

DECISION AND ORDER

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

ISSUES

A contested case hearing was held on January 18, 2017, to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the Claimant is not entitled to psychotherapy for PTSD for the compensable injury of (Date of Injury)?

PARTIES PRESENT

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

BACKGROUND INFORMATION

Claimant sustained a compensable injury on (Date of Injury) from a motor vehicle accident. Claimant has received 24 sessions of psychotherapy. Notations from the Utilization Review reports noted that on July 10, 2014, Claimant's depression had worsened and he wanted to restart counseling. NP, M.D., requested pre-authorization for an additional sessions of psychotherapy for post-traumatic stress disorder (PTSD). The IRO decision upheld the previous denials, and Claimant appealed.

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 (t), "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 cognitive therapy in connection with depression:

> ODG Mental Illness and Stress – Cognitive therapy for depression
>
> Recommended. Cognitive behavior therapy for depression is recommended based on meta-analysis that compare its use with pharmaceuticals. Cognitvie 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 postteramtnet between telephone and face-to-face CBT. However, face-to-face CBT was signficiantly 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 memoies, 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, an MD specializing in Family Medicine, thought the requested treatment was not medically necessary, noting Claimant received "several" sessions of psychotherapy from which he did not show any improvement. The IRO doctor also observed that there was no recent reassessment submitted for review with updated psychometric testing measures and that the

request was nonspecific and did not indicate the frequency and duration of the requested treatment.

Claimant testified there was improvement, and he needed the additional psychotherapy sessions to improve his mental health status because without therapy, he felt lost and confused. There was a letter to that effect from LD, M.Ed., LPC, LCDC, USAF Ret. TSgt. Dr. D noted Claimant had made gradual progress and improvement but due to the intermittent nature of approval for his sessions, there was a tendency to regress in his treatment. However, neither Claimant nor Dr. D cited the ODG treatment guidelines or any other evidence based medical evidence to support their position. Moreover, there was insufficient medical evidence presented to show that Claimant was making sufficient progress at his prior sessions in order to show the current request for additional sessions is medically necessary under the ODG.

There was no objection to the testimony, reports, or qualifications of any doctor.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

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.

   F. The Texas Department of Insurance appointed C-IRO, Inc., as the independent review organization (IRO) in this matter.

   G. The IRO determined that the proposed psychotherapy for PTSD is not health care reasonably required/ medically necessary for the compensable injury of (Date of 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 request for psychotherapy for PTSD is 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 psychotherapy for PTSD for the compensable injury of (Date of Injury).

DECISION

The preponderance of the evidence is not contrary to the decision of the IRO that the Claimant is not entitled to psychotherapy for PTSD 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

ROBIN MILLER
5221 N. O'CONNOR BLVD., SUITE 400
IRVING, TEXAS 75039-3711

Signed this 27th day of January, 2017.

Dee Marlo Chico
Hearing Officer