

Case Number:	CM13-0063142		
Date Assigned:	12/30/2013	Date of Injury:	12/22/1996
Decision Date:	08/04/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/09/2013

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 Psychiatry & Neurology, and Addiction Medicine has a subspecialty in Geriatric Psychiatry and is licensed to practice in California and Texas. 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:

Records reviewed include 966 pages of medical and administrative records. The injured worker is a 70 year old male whose diagnosis is major depressive disorder, single episode, severe. His date of injury is 10/22/1996 in which he lifted a 90 lb jackhammer above his shoulders resulting in pain in both shoulders and neck. He was treated with cortisone injections, physical therapy, medications, and surgical repair of rotator cuff tear. He was diagnosed with depressive disorder not otherwise specified in 10/99 and was treated with psychotherapy and medication management. In his AME of 04/17/08 the patient's symptoms were loss of interest, irritability, tearfulness, sleep problems, and depression. He was on Effexor at that time. His Beck Depression Inventory (BDI)=21, Beck Anxiety Inventory (BAI)=22. By this time the patient had received around 400 psychotherapy sessions. Further individual psychotherapy sessions at every other week for 2 years, but did not believe he would require further after that. Monthly PR-2's from The Friedman Psychiatric Medical Group were reviewed. The patient consistently complained of anxiety, depression, sleep disturbance, and nightmares. His anxiety was focused on cardiac issues (e.g. having another stint placed or having a heart attack). Objectively he was consistently described as depressed. BDI's from 07/31/13-12/5/13 ranged from 21-24, BAI's from 24-27. I did not see reference to what medication the patient was prescribed, however there were requests for medication management. UR certification approved sertraline. No further psychiatric/psychological records were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 SESSIONS OF GROUP PSYCHOTHERAPY (2 TIMES A MONTH FOR 24 WEEKS):
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, Cognitive Therapy for Depression.

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, Group Therapy, Post Traumatic Strss Disorder (PTSD), and psychotherapy interventions.

Decision rationale: CA-MTUS does not address group therapy. ODG recommends group therapy as an option. Group therapy should provide a supportive environment in which a patient with Post-traumatic stress disorder (PTSD) may participate in therapy with other PTSD patients. While group treatment should be considered for patients with PTSD, current findings do not favor any particular type of group therapy over other types. Per ODG PTSD Psychotherapy interventions are aimed at reduction of symptoms severity and improvement of global functioning. However, the clinical relevance and importance of other outcome indicators (e.g., improvement of quality of life, physical and mental health) are not currently well known.) 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. Since the patient's AME of 04/17/2008, the patient has remained subjectively and objectively depressed and anxious. At that time he had already received approximately 400 psychotherapy sessions, his BDI was 21 and BAI was 22. His most recently documented scores through 12/05/13 have ranged from BDI=21-24 and BAI=24-27, showing that the patient had in fact remained the same or worsened on occasion. In addition, it is unclear whether or not he is receiving medication management. In cases of severe major depression up to 50 sessions is recommended per ODG if progress is being made. This patient has had at least 400 sessions with no apparent progress. It would appear therefore that the patient would now be stationary as to the effects of any psychotherapy treatment. Therefore this request is not medically necessary.

24 INDIVIDUAL THERAPY SESSIONS (ONCE A WEEK FOR 24 WEEKS): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Therapy for Depression, Psychotherapy Guidelines, and 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) Mental Illness & Stress, Cognitive therapy for depression.

Decision rationale: CA-MTUS does not reference psychotherapy related to major depressive disorder, therefore ODG was utilized. Cognitive therapy is 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). It also fared well in a meta-analysis comparing 78 clinical trials from 1977 -1996.) In another study, it was found that combined therapy (antidepressant plus psychotherapy) was found to be more effective than psychotherapy alone.) A recent high quality study concluded that a substantial number of adequately treated patients did not respond to antidepressant therapy.) A recent meta-analysis concluded that psychological treatment combined with antidepressant therapy is associated with a higher improvement rate than drug treatment alone. The gold standard for the evidence-based treatment of MDD is a combination of medication (antidepressants) and psychotherapy. Maintenance cognitive-behavioral therapy (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 prior 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.) 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. Since the patient's AME of 04/17/2008 the patient has remained subjectively and objectively depressed and anxious, At that time he had already received approximately 400 psychotherapy sessions, his BDI was 21 and BAI was 22. His most recently documented scores through 12/05/13 have ranged from BDI=21-24 and BAI=24-27, showing that the patient had in fact remained the same or worsened on occasion. In addition, it is unclear whether or not he is receiving medication management. In cases of severe major depression up to 50 sessions is recommended per ODG if progress is being made. This patient has had at least 400 sessions with no apparent progress. It would appear therefore that the patient would now be stationary as to the effects of any psychotherapy treatment. Therefore this request is not medically necessary.