

<b>Case Number:</b>	CM14-0140131		
<b>Date Assigned:</b>	09/08/2014	<b>Date of Injury:</b>	04/06/1995
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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 Psychology and is licensed to practice in California. 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:

The claimant is an unknown age male with a date of injury of 4/6/95. The claimant sustained injury while working for [REDACTED]. The claimant's age, mechanism of injury, nor the injured body parts were found within the medical records submitted for review. It is reported that the claimant has been receiving psychiatric and psychological services. In the only medical report submitted for review dated 8/8/14, treating psychologist, [REDACTED], diagnosed the claimant with Major depressive disorder, single episode, severe, without psychotic features.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Group Therapy 1 time per week for 3 months (12 sessions) for depressive disorder as outpatient:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman and Gilman's The Pharmacological Basis of Therapeutics, 12th ed. McGraw Hill, 2010. Physician's Desk Reference, 68th ed. www.RxList.com ODG Workers Compensation Drug Formulary, www.odg-twc.com/odgtwc/formulary.htm drugs.com Epocrates Online, www.online.epocrates.com Monthly Prescribing Reference, www.empr.com Opioid Dose Calculator-AMDD Agency Medical Directors' Group Dose Calculator, www.agencymeddirectors.wa.gov (as applicable)

**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 and Stress Chapter Cognitive therapy for depression 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). (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 posttreatment 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) Psychotherapy visits are generally separate from physical therapy visits. ODG Psychotherapy Guidelines: Initial trial of 6 visits over 6 weeks With evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions) Other Medical Treatment Guideline or Medical Evidence: The American Psychiatric Association Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2010) (pgs. 48-49 of 118) Group therapy Group psychotherapy is widely practiced, but research on its application to major depressive disorder is limited. Specific types having some data to support their efficacy include CBT (344-347) and IPT (348-351). Meta-analyses of the relative effectiveness of psychotherapeutic approaches conducted in group format versus individual format have not involved patients with rigorously defined major depressive disorder (352-355). On the basis of a very limited controlled study, supportive group therapy has been suggested to have utility in the treatment of major depressive disorder. In a study of depressed outpatients, a mutual support group and group CBT were found to be equally effective in reducing depressive symptoms (346). In a study of HIV-positive patients with mild to moderate major depressive disorder, structured supportive group therapy plus placebo yielded similar decreases in depressive symptoms to structured group therapy plus fluoxetine (356). Individuals experiencing stressor.

**Decision rationale:** The CA MTUS does not address the treatment of depression nor the use of group therapy therefore, the Official Disability Guideline regarding the cognitive treatment of depression and the APA Practice Guideline for the Treatment of Patients with Major Depressive Disorder will be used as references for this case. Based on the review of the very limited medical records submitted for review, the claimant has been receiving psychotherapy services (both individual and group therapy) for some time. However, there was no information indicating how long the claimant has been receiving services, how many services he has received, the treatment plan for all of the services, the interventions used, nor the response to all of the services as there was only one report submitted for review. Without more information to substantiate the request for additional services, the need for additional sessions cannot be fully determined. As a result, the request for "12 Group Therapy 1 time per week for 3 months (12 sessions) for depressive disorder as outpatient" is not medically necessary.