

Independent Medical Review Final Determination Letter

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Dated: 12/27/2013

IMR Case Number:	CM13-0016972	Date of Injury:	03/15/2010
Claims Number:	[REDACTED]	UR Denial Date:	08/02/2013
Priority:	STANDARD	Application Received:	08/27/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]		
Treatment(s) in Dispute Listed on IMR Application:			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. This means we decided that all of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

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 licensed 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant is a 42 y.o. female (DOB [REDACTED]) with a date of injury of 3/15/10. According to medical records, the claimant has struggled with chronic pain involving her shoulder, neck, back, and leg. In addition to the medical issues that she struggles with, she has been diagnosed with Major Depressive Disorder and Panic Disorder without Agoraphobia.

IMR DECISION(S) AND RATIONALE(S)

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

1. 6 (six) cognitive behavioral therapy (CBT) sessions is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), Cognitive Behavioral Therapy, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 23, which is part of the MTUS; and the Official Disability Guidelines (ODG), Cognitive Behavioral Therapy, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

According to Dr. [REDACTED] most recent report dated July 15, 2013, the claimant continues to struggle with depression, as evidenced by both subjective report and the claimant's BDI scores. The claimant actually experienced an exacerbation in depressive symptoms due to new pain issues in her shoulder, which had yet to be managed

effectively through physical medicine. According to the Official Disability Guidelines, an “initial trial of 6 visits over 6 weeks” is suggested and “with evidence of objective functional improvement, total of up to 13-20 visits over 13-20 weeks (individual sessions)” can be authorized. Prior to the claimant experiencing the exacerbation in symptoms, she appeared to have been benefitting from the cognitive behavioral therapy per reports. Since she has only received 5 sessions from Dr. [REDACTED], a request for an additional 6 sessions appears appropriate and thus, medically necessary.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient’s physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

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