

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



---

**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/31/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/29/2013  
Date of Injury: 1/5/2009  
IMR Application Received: 7/29/2013  
MAXIMUS Case Number: CM13-0007404

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 a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Psychiatry, 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 physician 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:

According to the documentation provided, the patient is a 59-year old individual who sustained an injury on 01/15/09. The patient's work included sewing clothes with a sewing machine, which involved prolonged sitting, repetitive use of the hands, occasional packing and quality control inspection. The patient developed depressive and anxious emotional complications of physical pain, disability, altered activities arising from industrial injuries involving primarily the right upper extremity, left hand, back and right knee. The emotional complications of the physical injuries may have adversely influenced by disturbing events at work. There was a peer non-certification for the request for Cognitive Behavior Therapy (CBT) 3-4 visits in the next 45 days; biofeedback 4 in next 6 months; and 5 sessions of medication management in the next 6 months on 7/26/13 by Dr. [REDACTED]

### IMR DECISION(S) AND RATIONALE(S)

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

**1. Cognitive Behavior Therapy (CBT) three (3) to four (4) visits in the next forty-five (45) days, then one (1) visit every other week (13 sessions) is medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Psychological treatment, pages 101-102, which is part of the MTUS. The Physician Reviewer also cited the Official Disability Guidelines (ODG), Mental illness and stress chapter, section on MDD treatment, mild presentations, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. The guidelines also indicate, "Current practice standards defer to patient preference for much of the treatment planning." The medical records provided for review indicate that a report dated on 4/10/13 mentioned that the psychotherapy decreased tension and pressure to reduced isolation and depression, and put the events of injury into a better perspective in the employee's life. This indicates that the employee benefitted from the psychological treatment. Based upon the employee's longstanding need for and benefit from the psychological treatment, the request is certified. **The request for Cognitive Behavior Therapy (CBT) three (3) to four (4) visits in the next forty-five (45) days, then one (1) visit every other week (13 sessions) is medically necessary and appropriate.**

**2. Biofeedback four (4) sessions over the next six (6) months as needed is medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 24-25, which is part of the MTUS. The Physician Reviewer also cited the Official Disability Guidelines (ODG), Biofeedback therapy, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that biofeedback is not recommended as a stand-alone treatment, but is recommended as an option in a cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. The ODG guidelines indicate that biofeedback should possibly be considered in conjunction with cognitive behavioral therapy after four weeks. The guidelines also indicate that with evidence of objective functional improvement, a total of up to six to ten visits over five to six weeks is recommended. The request meets guideline recommendations. **The request for biofeedback four (4) sessions over the next six (6) months as needed is medically necessary and appropriate.**

**3. Medication management one (1) session in the next 45 days, and then every two to three (2-3) months (4 sessions) over the next six (6) months as needed is medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines (ODG).

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Gabapentin and Bupropion (Wellbutrin), pages 18 and 27, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that bupropion is recommended as an option after other agents. The guidelines also indicate that gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a

first-line treatment for neuropathic pain. Accepted medical practice for medications such as bupropion are required to be monitored for effectiveness and adverse effects on a regular and ongoing basis. The request represents a minimal frequency in order to monitor and manage potentially dangerous adverse effects as well as to ensure that the combination of dangerous prescription medications are in fact helping the employee, and are not in need of change or possible discontinuation. Any fewer medication management sessions would not allow the prescribing physician to safely manage the employee. **The request for medication management one (1) session in the next 45 days, and then every two to three (2-3) months (4 sessions) over the next six (6) months as needed is medically necessary and appropriate.**

/sh

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]

CM13-0007404