

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

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



Notice of Independent Medical Review Determination

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	4/1/2012
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0006945

- 1) MAXIMUS Federal Services, Inc. has determined the request for **psych individual therapy once a month for three months is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Omnicapl #30 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/4/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **psych individual therapy once a month for three months is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Omnicapl #30 is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision 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 New York. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This case involves a divorced 52 year-old male newspaper deliveryman who sustained a work related back injury on April 1, 2012. The patient identified no previous psychiatric history, but following the injury he developed affective and anxiety symptomatology. On 11/29/12, the patient was diagnosed with major depressive disorder, anxiety disorder not otherwise specified and pain disorder associated with both psychological factors and a general medical condition. Psychological treatment was deemed medically necessary. The requests for monthly psychotherapy and daily multivitamin therapy were not certified by the insurer.

Documents Reviewed for Determination:

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

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for psych individual therapy once a month for three months:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Guidelines which is part of MTUS. The Claims Administrator also based its decision on the Official Disability Guidelines (ODG) which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Behavioral interventions, pg. 23, and pgs. 101-102, Psychological treatment, which is a part of the MTUS, also based his/her decision on the following references which are not part of MTUS:

1. Sharp J, Keefe B. "Psychiatry in Chronic Pain: A Review and Update,." FOCUS. 2006;4(4):573-580.
2. Chou R, et al. "Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society," Annals of Internal Medicine. 2007;147(7):478-491.
3. The American Psychiatric Publishing Textbook of Psychiatry, 5th Edition. Chapter 25, Pain Disorders, Raphael J. Leo, M.D. accessed at <http://psychiatryonline.org/content.aspx?bookid=3§ionid=1345191>.

Rationale for the Decision:

Behavioral pain management therapy is consistent with good medical practice in the United States and supported by peer-reviewed medical literature including the Chronic Pain Medical Treatment Guidelines which states, "Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective." It is a safe and cost effective intervention. Since this treatment is in accordance with generally accepted standards of medical practice and is clinically appropriate with a reasonable expectation to improve the employee's condition, behavioral pain management services are medically necessary for treatment of the employee's condition. **The request for psych individual therapy once a month for three months is medically necessary and appropriate.**

2) Regarding the request for Omnicap #30:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Guidelines which is a part of the MTUS. The Claims Administrator also based its decision on the Official Disability Guidelines (ODG) which is not a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Chronic Pain update, 2008, page137, Vitamins, which is not a part of the MTUS.

Rationale for the Decision:

An exhaustive search of the current peer-reviewed literature failed to return any well-designed and adequately powered studies illustrating the application of daily multi-vitamin therapy in the treatment of back pain. Additionally, the treatment is not mentioned in the Chronic Pain Medical Treatment Guidelines. Further, vitamins are not recommended for treatment of chronic low back or other chronic pain if documented deficiencies or other nutritional deficit states are absent. **The request for Omnicapl #30 is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sm

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.