

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: 10/28/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	5/22/2013
Date of Injury:	4/17/2013
IMR Application Received:	6/10/2013
MAXIMUS Case Number:	CM13-0000610

- 1) MAXIMUS Federal Services, Inc. has determined the request for chiropractic care 3 times a week for two weeks for the thoracic and left shoulder **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/10/2013 disputing the Utilization Review Denial dated 5/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/26/2013. 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 chiropractic care 3 times a week for two weeks for the thoracic and left shoulder **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Doctor of Chiropractic who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Licensed in Chiropractic Medicine, 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated May 22, 2013:

“According to the medical report dated 05/17/13 by Dr. [REDACTED], the patient complained of pain, stiffness and swelling of the left shoulder girdle, rotator cuff region. Physical examination showed that there was difficulty increasing ranges of motion in a passive/active manner. According to the medical records dated 04/25/13 by Dr. [REDACTED], the patient complained of pain of the neck, shoulder and left ring finger and pins and needles on the left arm. Physical examination showed that there was positive Solo hall test, as well as positive cervical compression test at C5-C6 region. The range of motion of the cervical spine in degrees: extension-30 with pain rate at 9/1 flexion-full range of motion but with pain at rate of 7/10, right lateral flexion-20 with pain rate of 8/10, left lateral flexion-35 with pain rate of 8/1 left rotation-60 with pain rate of 7/10 and right rotation-50 with pain rate of 7/10. The patient's height and weight were not documented. The patient was diagnosed with pain in joint, shoulder region, pain in thoracic spine, cervicobrachial syndrome (diffuse) and cervicalgia.”

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 for Independent Medical Review (received 6/10/2013)
- Utilization Review Determination from [REDACTED] (dated 5/22/2013)
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for chiropractic 3 times a week times two weeks thoracic and left shoulder:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) pages 173-175, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2008) pages 555-556, which is a medical treatment guideline that is not part of the MTUS. The Claims Administrator further cited the Official Disability Guidelines (ODG) Chiropractic Guidelines, Therapeutic Care section, Sprains and Strains of the Shoulder and Upper Arm section, and Shoulder Manipulation section, which are medical treatment guidelines that are not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 4/17/2013 to the neck, left shoulder, left ring finger, and left arm. The medical records provided for review indicate a diagnosis of pain in joint, shoulder region, pain in thoracic spine, cervicobrachial syndrome (diffuse) and cervicalgia. The medical report of 5/17/2013 documents that the employee experienced pain, stiffness and swelling of the left shoulder girdle and rotator cuff region, physical examination showed that there was difficulty increasing ranges of motion in a passive/active manner. The medical records provided for review indicate treatments have included 12 visits of chiropractic manipulation and mechanical traction. The request is for chiropractic 3 times a week times two weeks thoracic and left shoulder.

The ACOEM Guidelines indicate manipulation by a manual therapist has been described as effective for individuals with frozen shoulders, and the period of treatment is limited to a few weeks, because results decrease with time. The medical records provided for review indicate that there had been 12 previous treatments which reported that the neck is 85 percent better with increased ranges of motion; however, there is no indication of the employee's functional improvement. The request for chiropractic 3 times a week times two weeks thoracic and left shoulder **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

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

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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.