
Independent Medical Review Final Determination Letter

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

Dated: Select Date

IMR Case Number:	CM13-0013964	Date of Injury:	04/29/1999
Claims Number:	[REDACTED]	UR Denial Date:	07/29/2013
Priority:	STANDARD	Application Received:	08/20/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]		
Treatment(s) in Dispute Listed on IMR Application:			
THERAPY : MANIPULATION, PHYSIOTHERAPY MODALITIES, MYOFACIAL RELEASE 2 X 4, OFFICE VISIT			

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: UPHOLD. This means we decided that none 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]
[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 physician reviewer is licensed in Chiropractic & Acupuncture 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 patient is 58 year old male who was involved in a work related injury on 4/29/1999. His diagnoses are cervical, thoracic and low back strain sprain and trochanteric bursitis. MRI shows moderate right sided foraminal narrowing at L5-S1 due to 5-6mm right far lateral disc herniation. At L4-5, there is mild to moderate bilateral stenosis due to a 3mm broad based posterior disc bulge. Prior treatment includes nerve blocks at L4-5, greater trochanteric bursa injection, physical therapy, home exercise program, oral medications, and chiropractic treatment. Office visit dated 3/28/13 notes that patient has low back pain that radiates to the right leg. The pain is described as constant sharp pain and tenderness to palpation over lumbar facets, bilateral lumbar and thoracic paraspinal muscles. The chiropractor submitted a letter stating that the patient has lifetime medical with periodic chiropractic treatments and that the patient has already had 24 visits with him as of 2/22/2014. There are also notes for 8 chiropractic treatments. However, no functional improvement were noted with the treatments. On 1/21/2013, the primary treating physician notes that the patient states that chiropractic treatment is very beneficial for pain.

IMR DECISION(S) AND RATIONALE(S)

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

1. The request for 8 sessions of chiropractic manipulation is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 58-60, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

According to evidence based guidelines, further chiropractic treatment after an initial trial is medically necessary with documented functional improvement. It is unclear how many chiropractic treatments have been already rendered. However, it is clear that employee has exceeded the recommended 24 limit for chiropractic. There is no functional improvement documented from the primary treating physician or the chiropractor as related to chiropractic treatments. **The request for 8 session of chiropractic manipulation is not medically necessary and appropriate.**

/dso

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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