

**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: 10/22/2013

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/1/2013
Date of Injury:	12/11/2010
IMR Application Received:	7/24/2013
MAXIMUS Case Number:	CM13-0003056

- 1) MAXIMUS Federal Services, Inc. has determined the request for chiropractic treatment for lumbar spine two times a week for three weeks **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 treatment for lumbar spine two times a week **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The Expert Reviewer who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is a Licensed Chiropractor, 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 utilization review determination did not contain a clinical summary.

### **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 8/8/2013)
- Utilization Review Determination from [REDACTED]
- Employee medical records from [REDACTED], M.D.
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request chiropractic treatment for lumbar spine two times a week for three weeks:**

#### 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), 2<sup>nd</sup> Edition, (2009) Chapter 12, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Chiropractic Guidelines, which is a medical treatment guideline that is not part of the MTUS. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 58-59, which are part of the MTUS.

Rationale for the Decision:

The employee has a date of injury of 12/11/10 resulting in a left shoulder impingement, s/p arthroscopy for RTC repair/SAD, bilateral knee DJD s/p arthroscopy and thoracic/lumbar DDD. Treatments have included medications, surgeries, chiropractic visits, and physical therapy. A request for lumbar spine two (2) times a week for three (3) weeks was submitted.

The MTUS Chronic Pain Guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of functional improvement, a total of up to 18 visits over 6-8 weeks. Clinical notes submitted for review indicates that the employee had been receiving chiropractic care on a weekly basis up until 2/28/2013. There were no medical records provided for review documenting any of these chiropractic treatments. There is no evidence of specific functional benefit, decrease of pain, or improvement in quality of life. The guideline criteria are not met. The request for chiropractic treatment for lumbar spine two (2) times a week for three (3) weeks **is not medically necessary or 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/skf

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.