

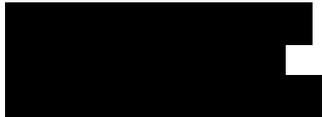
MAXIMUS FEDERAL SERVICES, INC.

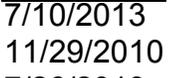
Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/31/2013



Employee:	
Claim Number:	
Date of UR Decision:	7/10/2013
Date of Injury:	11/29/2010
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0003943

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for six (6) chiropractic visits between 7/15/2011 and 8/30/2011 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for six (6) acupuncture visits between 7/15/2011 and 8/30/2011 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for one (1) cervical epidural steroid injection between 7/15/2011 and 7/22/2011 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/6/2013. 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 retrospective request for six (6) chiropractic visits between 7/15/2011 and 8/30/2011 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for six (6) acupuncture visits between 7/15/2011 and 8/30/2011 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for one (1) cervical epidural steroid injection between 7/15/2011 and 7/22/2011 **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 Physical Medicine and Rehabilitation, 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 July 11, 2013:

The patient is a 35-year-old female with a date of injury of 11/29/2010. The provider has submitted a retrospective request for 6 continued chiropractic visits, 6 continued acupuncture visits, and a cervical epidural steroid injection.

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 (received 7/29/2013)
- Utilization Review Determination from Claims Administrator
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the retrospective request for six (6) chiropractic visits between 7/15/2011 and 8/30/2011:

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 Chronic Pain Medical Treatment Guidelines (2009), Manual therapy & manipulation, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pg. 58 Manual therapy & manipulation, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was being treated for chronic neck, low back and right shoulder complaints. The employee reported a flare up of neck complaints with radiation to the bilateral upper extremities and head. The patient also reported persistent right shoulder pain. Prior treatment included acupuncture, chiropractic and medications. The request is for six (6) chiropractic visits between 7/15/2011 and 8/30/2011.

The MTUS guidelines states manipulative therapy beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. Medical records submitted and reviewed indicate the employee had undergone chiropractic treatment between 12/1/10 and 4/13/11 at a frequency of at least 2 times a week and was then treated once a week until 7/15/11. Medical records did not show indication of significant sustained improvements in function or clinical findings due to the prolonged course of chiropractic care. The criteria has not been met. **The request for six (6) chiropractic visits between 7/15/2011 and 8/30/2011 is not medically necessary and appropriate.**

2) Regarding the retrospective request for six (6) acupuncture visits between 7/15/2011 and 8/30/2011:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter. The Expert Reviewer relied on Acupuncture Medical Treatment Guidelines (2009), which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was being treated for chronic neck, low back and right shoulder complaints. The employee reported a flare up of neck complaints with radiation to the bilateral upper extremities and head. The patient also reported persistent right shoulder pain. Prior treatment included acupuncture, chiropractic and medications. The request is for six (6) acupuncture visits between 7/15/2011 and 8/30/2011.

The MTUS guidelines state that acupuncture treatments may be extended if functional improvement is documented after the initial 6 visits, meaning either a clinically significant improvement in activities of daily living or a reduction in work restrictions. Medical records submitted and reviewed indicate the employee has had acupuncture treatments in the past but there are no reports to determine whether or not they resulted in improvements of pain and function. The criteria has not been met. **The request for six (6) acupuncture visits between 7/15/2011 and 8/30/2011 is not medically necessary and appropriate.**

3) Regarding the retrospective request for one (1) cervical epidural steroid injection between 7/15/2011 and 7/22/2011:

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 Chronic Pain Medical Treatment Guidelines (2009), Epidural Steroid Injection section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pg. 46, Epidural steroid injections (ESIs), which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was being treated for chronic neck, low back and right shoulder complaints. The employee reported a flare up of neck complaints with radiation to the bilateral upper extremities and head. The patient also reported persistent right shoulder pain. Prior treatment included acupuncture, chiropractic and medications. The request is for one (1) cervical epidural steroid injection between 7/15/2011 and 7/22/2011.

MTUS guidelines indicate the criteria for the use of epidural steroid injections state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Medical records submitted and reviewed indicate the employee did not have consistent subjective findings indicating pain in a dermatomal pattern in the upper extremities. No MRI reports were provided for review. Without such reporting, the presence of intervertebral disk herniation or stenosis cannot be established to corroborate the presence of cervical radiculopathy required by MTUS. The criteria has not been met. **The request for one (1) cervical epidural steroid injection between 7/15/2011 and 7/22/2011 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

/ldh

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.