

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/11/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	2/4/2013
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0006574

- 1) MAXIMUS Federal Services, Inc. has determined the request for Chiro x cervical thoracic spine **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 8/30/2013. 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 Chiro x cervical thoracic spine 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 Chiropractor, has a subspecialty in 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

Disclaimer: The following case summary was taken from a previous utilization review denial/modification dated 7/25/2013.

The patient is a female with a date of injury of 2/4/2013. According to the UR dated 7/25/2013, the provider's PR2 dated 7/02/2013 states that the patient complained of continued neck and upper back pain. Significant objective findings include positive shoulder depression bilaterally, full cervical range of motion, and full thoracic range of motion. The patient was diagnosed with brachial neuritis/radiculitis NOS. The patient has completed 19 chiropractic sessions from 4/19/2013 to 7/19/2013. Electrodiagnostic studies dated 8/21/2013 by Dr. [REDACTED] MD were unremarkable. Dr. [REDACTED] concluded that there was no evidence of an upper extremity peripheral entrapment neuropathy or cervical radiculopathy. Cervical and thoracic spine MRI report dated 6/28/2013 by Dr. [REDACTED] MD revealed 1mm retrolisthesis C3 on C4 in neutral and in extension with no stenosis. There was no retrolisthesis of C3 on C4 in flexion. Straightening of the cervical lordosis was seen which is consistent with musculoskeletal strain. Thoracic spine revealed no disc herniation, stenosis, alteration of the caliber of the central canal or foramina. There was no cord compression.

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 Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Chiro x cervical thoracic spine:

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, Manipulation, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Manual Therapy & Manipulation, pages 58-60, which are part of MTUS.

Rationale for the Decision:

According to the MTUS guidelines, chiropractic manipulation is recommended as a trial of 6 visits over two weeks with a total of 18 visits over 6-8 weeks with evidence of objective functional improvement. Records indicated that the employee had received a total of 19 chiropractic visits from 4/19/2013 to 7/19/2013. There was no evidence of functional improvement or flare-up's in the provided documentation. In addition, the employee has exceeded the number of recommended visits stated in the guidelines. **The request for Chiro x cervical thoracic spine 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

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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.