

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/20/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/1/2013
Date of Injury:	6/18/2009
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007114

- 1) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic with physiotherapy for the shoulders/hands QTY: 6.00 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **internal medicine evaluation QTY: 1.00 is 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 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/10/2013. 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 with physiotherapy for the shoulders/hands QTY: 6.00 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **internal medicine evaluation QTY: 1.00 is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Expert Reviewer who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in 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:

According to the available medical records, this patient presented with chronic neck, shoulders and wrists pain from an injury dated 6/18/2009. The claimant underwent surgeries on both wrists and right shoulder. Besides surgeries, previous treatments include chiropractic, physical therapy, pain medication, home stim unit, and psychiatric evaluation. The claimant was P&S for the injuries with impairment and future medical including orthopedic follow-up, wrist brace, physical therapy, medications, home therapy equipment, exercise equipment, adjustments, chiropractic treatment, acupuncture, epidurals and further surgery if necessary.

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 chiropractic with physiotherapy for the shoulders/hands QTY: 6.00:**

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 MTUS ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, (2004), page 203, the Chronic Pain Treatment Guidelines, Physical medicine guidelines, which are part of the MTUS and the Official Disability Guidelines (ODG), Physical Therapy Guidelines, Manipulation under anesthesia, Manipulation of the shoulder, and Chiropractic guidelines, which is not part of the MTUS.

The Expert Reviewer based his/her decision on Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), page 203, the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), page 265, and the Chronic Pain Medical treatment Guidelines, Chronic pain, page 58-59, which are part of the MTUS

Rationale for the Decision:

The MTUS Chronic Pain Guidelines does not address chiropractic as a treatment option for chronic shoulder pain, but indicates it is not recommended for the treatment of hand and wrist pain or carpal tunnel syndrome. The MTUS/ACOEM guidelines only recommends manipulation for patients with frozen shoulders and the period of treatment is limited to a few weeks, because results decrease with time. **The request for chiropractic with physiotherapy for the shoulder/hands is not medically necessary and appropriate.**

2) Regarding the request for internal medicine evaluation QTY: 1.00:

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 American College of Rheumatology (ACR) 1990, criteria for the classification of fibromyalgia: Report of the Multicenter Criteria Committee. Arthritis Rheum 1990; 33(2):160-72. (IV), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Pain Interventions and Treatments, page 11-22, which is part of the MTUS.

Rationale for the Decision:

According to Chronic Pain Medical Treatment Guidelines pain medication should be recommended on a case-by-case basis. A review of the records indicates the employee has chronic neck, shoulders and wrists pain that persists beyond the anticipated time of healing. There has been no improvement/relief with over the counter pain medications, the use of a home stimulation unit, exercise, or paraffin baths. **The request for internal medicine evaluation, quantity 1 is 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

/bh

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.