MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: **12/4/2013**

Employee:	
Claim Number:	
Date of UR Decision:	7/24/2013
Date of Injury:	12/5/2011
IMR Application Received:	8/13/2013
MAXIMUS Case Number:	CM13-0010633

1) MAXIMUS Federal Services, Inc. has determined the request for **six (6) chiropractic sessions for the lumbar spine** is not **medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **bilateral L4-S1 trigger point injections (total 6 points)** is not **medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 7/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/18/2013. 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 **six (6) chiropractic sessions for the lumbar spine** is not **medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **bilateral L4-S1 trigger point injections (total 6 points)** 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 Ohio, Pennsylvania. 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:
This patient is a 56-year-old woman with a reported date of injury of 12/05/2011 who fell at home. The patient has been diagnosed with lumbar radiculopathy, herniated lumbar disc, pain-related insomnia, myofascial pain syndrome, neuropathic pain, and narcotic dependence. The initial review noted that recent physical examination findings have noted limited lumbar range of motion with positive straight leg raising on the right and tenderness over the sacroiliac joint and lumbar spine and with trigger points over the lumbar spine. Initial review recommended noncertification of additional chiropractic given the lack of documented functional gains or other improvement from prior chiropractic therapy. That prior review also recommended noncertification of trigger point injections given that there was no comprehensive description of attempts at conservative care to date and given that it was uncertain whether the patient had prior attempts at trigger point injections.

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 six (6) chiropractic sessions for the lumbar 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, Low Back Complaints, pg. 58 and pg. 12, and American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004)-Low Back Chapter, pgs 298-299, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation, pg. 58, which is part of the MTUS.

Rationale for the Decision:
With regard to the request for additional chiropractic treatment, the California Medical Treatment Utilization Schedule would recommend continued treatment if there is evidence of objective functional improvement. The medical records do not document such prior objective functional improvement from previous chiropractic treatments, and therefore the treatment guidelines and records do not support additional chiropractic treatments. **The request for six (6) chiropractic sessions for the lumbar spine is not medically necessary and appropriate.**

2) **Regarding the request for bilateral L4-S1 tirgger point injections (total 6 points):**

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, Low Back Complaints, pg. 58 and pg. 12, and American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Low Back Chapter, pgs. 298-299, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Trigger Point Injections, pg. 122, which is part of the MTUS.

Rationale for the Decision:
The California Chronic Pain Medical Treatment Guidelines state that criteria for trigger point injections includes documentation of a circumscribed trigger point with evidence upon palpation of a twitch, failure of specifically defined prior treatment, in the absence of radiculopathy. At this time the medical records do not meet any of these criteria. It is not clear that this patient has documentation of a circumscribed trigger point. The medical records do not clearly indicate that this patient meets the criteria for defined prior treatment, and the patient does have findings of a radiculopathy by imaging and exam. **The request for bilateral L4-S1 trigger point injections (total 6 points) 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

/sb

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.