

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/30/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 0827/2013
Date of Injury: 07/28/2006
IMR Application Received: 08/30/2013
MAXIMUS Case Number: CM13-0018598

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. This means we decided that all of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is licensed in Chiropractic, 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the available medical records, this is a 57 year old male patient with chronic right shoulder pain, right wrist pain, neck and thoracic pain, date of injury 07/28/2006. Previous treatments include physical therapy, chiropractic, injection, pain control patches and work modification. There was no treatment records from August 2010 to 08/12/2013. PR-2 report on 08/12/2013 by Dr. [REDACTED] report a flare-up of his neck, back and right wrist pain with additional complain of left-sided upper back pain, weak in right arm; exam findings include restricted cervical ROM with pain, positive Maximum foraminal encroachment, shoulder depression, cervical compression, right cozen's, right Mill's, right Tinel's sign. Moderate to severe tenderness in bilateral upper traps/levator scap/rhomboids/cervical paraspinals/right forearm extensors and right volar wrist, grip strength: R 64 L 70 R 80 L 65; diagnosis are cervical disc herniation, thoracic sprain/strain complicated by scoliosis, right CTS/radiculopathy; treating doctor requesting 6x chiropractic sessions, 4 had been authorized.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Chiropractic treatment x six (6) visits is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Chronic Pain Section, pages 58-59, which is part of the MTUS.

The Expert Reviewer's decision rationale:

After complete review of the available medical records, the request for 6 chiropractic treatments is within the recommendation of the California MTUS Guideline and therefore, it is medically necessary. **The request for Chiropractic treatment x six (6) visits is medically necessary and appropriate.**

/JR

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.

[REDACTED]

CM13-0018598