

Independent Medical Review Final Determination Letter

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Dated: 12/26/2013

IMR Case Number:	CM13-0018600	Date of Injury:	03/18/1999
Claims Number:	[REDACTED]	UR Denial Date:	08/20/2013
Priority:	STANDARD	Application Received:	08/30/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] D.C.		
Treatment(s) in Dispute Listed on IMR Application:			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

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: UPHOLD. This means we decided that none 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]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician 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 71 year-old female patient with chronic left shoulder and right knee pain, date of injury 03/18/1999. PR-2 report on 03/15/2013 by Dr. [REDACTED] revealed persistent pain, stiffness of left shoulder, right knee, tenderness, limited Rom of left shoulder, right knee; diagnosis include left shoulder sprain/strain, impingement syndrome of left shoulder, status pos arthroscopy right knee; treatment include medication and chiropractic.

IMR DECISION(S) AND RATIONALE(S)

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

1. Six sessions of chiropractic manipulation to the left shoulder is not medically necessary and appropriate.

The Claims Administrator based its decision on the [[Insert Guidelines used]].

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Chapter 9, page 203, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM recommended manipulation for frozen shoulder and treatment is limited to a few weeks. According to the available medical records, this patient has impingement

syndrome and chronic sprain/Strain, and therefore, six sessions of chiropractic manipulation to the left shoulder is NOT medically necessary.

2. Six sessions of chiropractic manipulation to the right knee is not medically necessary and appropriate.

The Claims Administrator based its decision on the [[Insert Guidelines used]].

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 58-59, which are part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS does not recommend chiropractic manipulation for knee. Therefore, the request for six sessions of chiropractic manipulation to the right knee is NOT medically necessary.

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]

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