

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/14/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	6/4/2013
IMR Application Received:	7/31/2013
MAXIMUS Case Number:	CM13-0005144

- 1) MAXIMUS Federal Services, Inc. has determined the request for **6 Chiropractic Treatments with Chiro adujstment trigger Point Therapy, Electric Muscle Stimulation, Heat, Ice, Vibratory Massage is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 Functional Restoration is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/14/2013. 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 **6 Chiropractic Treatments with Chiro adujstment trigger Point Therapy, Electric Muscle Stimulation, Heat, Ice, Vibratory Massage is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 Functional Restoration 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 Certified in:Chiropractor, 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:

Patient is a 31 year old female who was injured on 6/4/2013. She has mid back pain low back pain and right leg and shoulder pain. It appears that the patient has had 12 chiropractic treatments at the time of the request. The exam dated 7/31/2013 notes that patient that the patient has increased ROM and decreased pain. There is no documentation of objective functional improvement associated with the treatment or discussion on why the patient is still on total disability. There is no documentation of the patient's job duties. There has been a functional capacity evaluation performed on 7/3/2013. No results have been submitted for that evaluation. Her diagnoses are cervicgia, lumbago, mid back pain, and right shoulder pain.

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 6 Chiropractic Treatments with Chiro adjustment trigger Point Therapy, Electric Muscle Stimulation, Heat, Ice, Vibratory Massage:

Section of the Medical Treatment Utilization Schedule (MTUS) Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Chapter 12 (Low Back Complaints) (2004), pgs. 299-300, 308, which are part of the MTUS; and ACOEM Guidelines, Chapter 12 (Low Back Complaints) (2007), pg. 161-162, which are not part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2nd Edition, (2004), Chapter 12, pages 300-308; and the Chronic Pain Medical Treatment Guidelines, Manipulation, therapy and manipulation, pages 58-60, which are part of the MTUS.

Rationale for the Decision:

According to the evidence-based guidelines, chiropractic care after an initial trial is recommended only with objective functional improvement. The medical records provided for review indicate that at the point of the request, the employee had already had a number of chiropractic treatment. No documentation of past functional improvement has been submitted for further chiropractic care. The ancillary modalities are excessive to be performed in a single treatment and many of the therapies can be performed at home, such as heat and ice. There is no proven efficacy for the TENS and massage techniques. **The request for 6 Chiropractic Treatments with Chiro adjustment trigger point therapy, Electric Muscle Stimulation, Heat, Ice, Vibratory Massage is not medically necessary and appropriate.**

2) Regarding the request for 1 Functional Restoration:

Section of the Medical Treatment Utilization Schedule (MTUS) Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM (2007), Chapter 12 (Low Back Complaints), pages 222 and 226, which are not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section 9792.20-9792.26 and pages 125-127, which are part of the MTUS.

Rationale for the Decision:

There are ten criteria for a work hardening or functional restoration program based on the recommended guidelines. The employee does not meet the ten criteria. The first criterion is that the employee must have a work-related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands. There is no documentation provided of what the employee's job demands are. A Functional Capacity Evaluation (FCE) has been ordered but no results are submitted. The guidelines recommend that a FCE showing consistent results with maximal effort, demonstrating capacities below an employer-verified physical demands analysis (PDA). The second criterion is that the employee has had an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning. There is no documentation of a trial of physical or occupational therapy. The next criterion recommends that there be physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. The employee is on total temporary disability as of the last submitted exam. The last few criteria state that there needs to be a defined return to work goal agreed to by the employer and employee and a documented specific job to return to with job demands that exceed abilities, or documented on-the-job training. There is no documentation of this nature. The employee does not meet the guideline criteria for the program. **The request for 1 Functional Restoration is no 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.