

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/24/2013
Date of Injury:	2/4/1998
IMR Application Received:	8/8/2013
MAXIMUS Case Number:	CM13-0008457

- 1) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic therapy two (2) times a week for two (2) weeks in treatment to the cervical and lumbar is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **x-ray lumbosacral comp. w/obl is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **x-ray thoracic AP&LAT is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/8/2013 disputing the Utilization Review Denial dated 7/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/9/2013. 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 therapy two (2) times a week for two (2) weeks in treatment to the cervical and lumbar is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **x-ray lumbosacral comp. w/obl is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **x-ray thoracic AP&LAT is not 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 expert reviewer is a Licensed Chiropractor and Licensed Acupuncturist, 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:

The patient is a 59-year-old male who sustained a work-related injury on 2/4/1998. He has neck and low back pain and radiating pain to the right shoulder. His diagnoses include cervical and lumbar disc with myelopathy and cervical and lumbar myofasciitis. The patient has had a number of treatments over the years including TENS, H-wave, home exercise, NSAIDs, cervical epidural steroid injection (ESI), acupuncture and chiropractic care. The patient has had 12 chiropractic sessions and 6 acupuncture sessions in the past year. Although patient states that he is improving with care, the office notes do not document any objective functional improvement. Cervical and lumbar spine range of motion appears to be decreased. The report states that the patient is able to do more physical activity with less pain but does not specify any details of the improvement. Finally, the report states the patient can sleep better due to not being woken up as much at night due to pain. The patient has developed increased pain in his back, especially in right flank area and mid line. He has no hematuria or prior history of kidney stones. He has full range of motion in the thoracic spine and no tenderness upon palpation.

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 therapy two (2) times a week for two (2) weeks in treatment to the cervical and lumbar:

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, Manual Therapy and Manipulation Section, pages 58-60, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation Section, pages 58-60, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain guidelines state that chiropractic care beyond an initial trial should be based on objective and measurable functional improvement. The records submitted for review include one report that mentions functional improvement but no measures are given to compare to the employee's level of function prior to treatment. Given the measureable factors, the employee's range of motion actually appears to be worse than prior to treatment. **The request for chiropractic therapy two (2) times a week for two (2) weeks in treatment to the cervical and lumbar is not medically necessary and appropriate.**

2) Regarding the request for x-ray lumbosacral comp. w/obl:

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 Official Disability Guidelines (ODG), Radiographs: Lumbar, which is 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 303 and 308, which are part of the MTUS, and the Official Disability Guidelines (ODG), Low Back, Radiography, which is not part of the MTUS.

Rationale for the Decision:

According to guidelines, radiographs are not recommended in the absence of red flags for fracture, cancer or infection for the lumbar spine. There are no indications that there are any of these red flags for the employee. **The request for x-ray lumbosacral comp. w/obl is not medically necessary and appropriate.**

3) Regarding the request for x-ray thoracic AP&LAT:

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 Official Disability Guidelines (ODG), Radiographs: Lumbar, which is part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Chapter 8, pages 177-178 and 182, which are part of the MTUS, and the Official Disability Guidelines (ODG), Low Back, Radiography, which is not part of the MTUS.

Rationale for the Decision:

According to guidelines, radiographs are not recommended in the absence of red flags for fracture, cancer or infection for the thoracic spine. There are no indications that there are any of these red flags for the employee. **The request for x-ray thoracic AP&LAT 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

/sab

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.