

Case Number:	CM13-0019874		
Date Assigned:	11/08/2013	Date of Injury:	11/22/1988
Decision Date:	02/04/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Licensed in Chiropractor , has a subspecialty in Acupuncture and is licensed to practice in Texas. 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

The patient is an 80-year-old male who reported an injury on 11/22/1988 due to a lifting injury. The patient was evaluated for an acute exacerbation of the patient's symptoms. The most recent clinical evaluation revealed reduced lumbar flexion, lumbar muscular tension bilaterally at the L4-5, and low back pain with a bilateral positive straight leg raising test. The patient's treatment plan included chiropractic care to address the patient's flare-ups.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment x 1, to include chiropractic manipulation, myofascial release, electric stimulation, and infrared heat: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

Decision rationale: The requested Chiropractic Treatment x 1, to include chiropractic manipulation, myofascial release, electric stimulation, and infrared heat is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has had a recent flare-up of the patient's chronic low back pain. California

Medical Treatment Utilization Schedule states recurrence and flare-ups "need to re-evaluate treatment success, if return to work is achieved then 1 to 2 visits every 4 to 6 months." The clinical documentation submitted for review does not provide any evidence that this 80-year-old patient is working and would benefit from chiropractic care. Additionally, there is no documentation that the patient is participating in any active therapy that would benefit from this passive modality. As such, the requested Chiropractic Treatment x 1, to include chiropractic manipulation, myofascial release, electric stimulation, and infrared heat are not medically necessary or appropriate.