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| Case Number: | CM14-0019864 | | |
| Date Assigned: | 04/28/2014 | Date of Injury: | 06/24/1998 |
| Decision Date: | 07/08/2014 | UR Denial Date: | 01/22/2014 |
| Priority: | Standard | Application Received: | 02/18/2014 |

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 Board Certified in Anesthesiology and Pain Medicine 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 injured worker is a 55-year-old male who sustained an injury to his low back on 06/24/98. The mechanism of injury was not documented. It was reported that the injured worker was authorized future medical treatment. The injured worker complained of low back pain that radiates to the left lower extremity. Pain with medications was 5/10 VAS and without medications was 8/10 VAS. Pain was increased with activity and walking. Physical examination noted range of motion of the lumbar spine was moderately limited secondary to pain. The injured worker experienced significant back pain with functional disability that impinges on all aspects of the patient's life; tenderness noted bilaterally in the paravertebral soft tissue structures from L3 through S1 and the left buttock; range of motion moderately limited secondary to pain; gait was slow and antalgic; ambulation with a cane. Unspecified chiropractic treatment has been requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58.

Decision rationale: The request for chiropractic treatment is not medically necessary. The frequency and duration was not specified in the request. The CAMTUS states that treatment with chiropractic manipulation therapy may be authorized for up to eight weeks. The injured worker is over 15 years post date of injury. There is no additional objective clinical information provided that would support the need to exceed the CAMTUS recommendations in duration of chiropractic manipulation therapy treatment. Given the clinical documentation submitted for review, medical necessity of the request for chiropractic treatment has not been established.