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| <b>Case Number:</b>   | CM14-0026025 |                              |            |
| <b>Date Assigned:</b> | 06/13/2014   | <b>Date of Injury:</b>       | 11/03/2011 |
| <b>Decision Date:</b> | 07/16/2014   | <b>UR Denial Date:</b>       | 02/19/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/28/2014 |

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 27 year old female who reported an injury on 11/03/2011 due to a slip and fall. On 01/24/2014 she reported a 6/10 tightness and discomfort that originated in the left hip which radiated to the groin. A physical assessment of the hip revealed no effusion, ecchymosis or deformities, slight tenderness in the left bursa, restricted abduction of the left hip, and normal range of motion and no tenderness to the knee joint. The lower back exam was within normal limits except for decreased sensation over the left peroneal nerve path. Her diagnoses included myositis, hip and thigh injury, and hip and thigh sprain. The patients past treatments included medication and chiropractic therapy. Medications included were ibuprofen. The treatment plan was for chiropractic therapy 2 times a week for 3 weeks for the left knee and lower back. The request for authorization form and rationale for treatment were not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC THERAPY 2 TIMES A WEEK TIMES 3 WEEKS FOR THE LEFT KNEE AND LOWER BACK:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

**Decision rationale:** The request for chiropractic therapy 2 times a week for 3 weeks for the left knee and lower back is not medically necessary. The injured worker was noted to have already attended six chiropractic therapy sessions with limited relief. The California MTUS Guidelines do not recommend chiropractic therapy for the knee. It is recommended as an option for the low back with a therapeutic care trial of six visits over 2 weeks with evidence of objective functional improvement, with 18 visits over 6-8 weeks. The injured worker reported having limited relief with the 6 sessions. In addition, the California MTUS guidelines state that the intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. There were no reports documented of the injured worker attending a therapeutic exercise program during the chiropractic sessions or that she had any functional improvement. The documentation does not have enough information needed to necessitate the request. Therefore, the request is not medically necessary.