

<b>Case Number:</b>	CM15-0143371		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	04/06/1999
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Minnesota  
 Certification(s)/Specialty: Chiropractor

### 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 63 year old female, who sustained an industrial injury on 4-6-1999. Diagnoses have included chronic lumbar pain with radiculopathy, left hip bursitis, bilateral shoulder tendinosis, bilateral carpal tunnel syndrome, depression and anxiety. Treatment to date has included lumbar surgery, spinal cord stimulator implantation, right hip surgery, chiropractic treatment and medication. According to the progress report dated 6-10-2015, the injured worker complained of worsening knee pain and left hip pain. She also complained of worsening neck, shoulder and upper extremity pain. She reported that her low back and lower extremity symptoms responded well to the stimulator. Physical exam revealed mild tenderness over the lumbar spine and decreased range of motion. There was limited range of motion of the bilateral shoulders. There was tenderness over the medial and lateral joints, especially on the left side with decreased flexion and positive McMurray's on both sides. Authorization was requested for chiropractic treatment for the left knee, twice a week for eight weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 chiro sessions, 2 times a week for 6 weeks, left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg.

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

**Decision rationale:** According to the MTUS Chronic Pain Guidelines above, manipulation of the knee is not recommended. The doctor has requested 12 chiropractic sessions or 2 times per week for 6 weeks to the left knee. The request for treatment is not according to the above guidelines and therefore the treatment is not medically necessary.