

<b>Case Number:</b>	CM15-0003913		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	05/23/2004
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	12/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 56 year old female who sustained an industrial related injury on 5/23/04. The injured worker had complaints of neck pain with radiation to the bilateral elbows and numbness to the hands. Diagnoses included thoracic outlet syndrome, cervical intervertebral cervical disc disorder with myelopathy, myofascitis, nerve root irritation, anxiety, depression, and status post cervical spinal fusion. The injured worker was prescribed Oxycodone HCL and OxyContin ER. On 1/8/15 the treating physician requested authorization for osteopathic manipulative therapy, unspecified frequency/duration, and unspecified body part. On 12/29/14 the request was non-certified. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted the request was not reasonable as there is no specific frequency, duration, or body part being requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Osteopathic manipulative therapy, unspecified frequency, duration, unspecified body part, per 12/18/14 form:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Pain Outcomes and Endpoints Page(s): 58-59, 8-9.

**Decision rationale:** The patient presents with neck pain with radiation to the bilateral elbows and numbness to the hands. The request is for OSTEOPATHIC MANIPULATIVE THERAPY, UNSPECIFIED FREQUENCY, DURATION, AND UNSPECIFIED BODY PART, PER 12/18/14. The RFA is not included. Patient's diagnosis on 12/12/14 included diagnoses included thoracic outlet syndrome, cervical intervertebral cervical disc disorder with myelopathy, myofascitis, nerve root irritation, anxiety, depression, and status post cervical spinal fusion. Patient is permanent and stationary. MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. In this case, chiropractic treatment history is not known. Given the patient's diagnosis, a short course of 6 sessions would be reasonable. However, the request is unspecified with respect to frequency, duration, and body part. Due to insufficient information available for assessment, the request IS NOT medically necessary.