

<b>Case Number:</b>	CM15-0018143		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	10/04/2013
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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 was a 34 year old female, who sustained an industrial injury on October 4, 2013, when the injured worker was trying to restrain a person. They both fell down and hit the floor. The injured worker immediately felt a sharp pain in the right shoulder. The second injury occurred on June 21, 2014. The injury occurred when two juveniles assaulted the injured worker in an enclosed area. The injured worker was punched and kicked. The injured worker fell face down and sustained multiple bruises, cuts, including a cut in the right orbital area with pain in the right cheek. The injured worker also sustained neck, back and extremity trauma. According to progress note of October 29, 2014, the injured workers chief complaint was headaches, pain in the right shoulder which was described as severe dull, achy, sharp, radiating to mid-arm and shoulder blade with numbness, weakness and cramping. Also, intermittent moderate burning left knee pain, numbness and weakness. The injured worker was diagnosed with headaches, numbness in the right side of the face, facial contusions and musculoskeletal injuries, right rotator cuff tear, bursitis of the right shoulder, partial tear right deltoid, left knee sprain/strain and left knee contusion. The injured worker previously received the following treatments MRI of the right knee on October 2, 2014, MRI of the lumbar spine on September 30, 2014 and an MRI of the right shoulder September 26, 2014. The documentation submitted for review consisted of a progress notes from October 6, 2014, October 29, 2014, MRI results of the right shoulder, MRI of the lumbar spine and an MRI of the right knee. On January 15, 2015, the UR denied authorization for continuation of physical therapy 2-3 times a week for 6 weeks, knee brace,

Mentherm cream, range of motion testing and urine toxicology. The denial was based on the MTUS/ACOEM and ODG guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical therapy 2 to 3 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**Decision rationale:** The 1/15/15 Utilization Review letter states the PT x 12-18 visits requested on the 1/06/2015 medical report was denied because the patient received authorization for postoperative PT x18 on 12/03/14, but the 1/06/15 report did not report if these visits were completed or whether there was any functional improvement. Unfortunately, the 1/06/2015 medical report was not provided for this review. Only the 10/06/14 neurology report, and 10/29/14 chiropractic report were provided for review, along with the 9/26/14 MRI studies of the right knee, lumbar spine, and right shoulder. There are no reports available from the requesting physician. None of the available reports discuss need for PT. The UR letter states that post operative PT was already approved, but did not discuss the type of surgery the patient had, if any or the date of the procedure. From the records provided for review, the patient has potential surgical conditions for the right knee, the lumbar spine and right shoulder. However, the 10/06/14 and 10/29/14 reports do not show that a surgical procedure had been performed. Without knowing if a surgery has been performed, or what body region was operated on, and date of surgery, the request cannot be accurately compared to the MTUS postsurgical medical treatment guidelines. MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine section, pages 98-99 states that 8-10 sessions of therapy are indicated for various myalgias or neuralgias. Based strictly off of the limited information provided, the request exceeds the MTUS Chronic Pain Medical Treatment Guidelines, and therefore IS NOT medically necessary.

**Knee brace, quantity: 1: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Knee Brace.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

**Decision rationale:** The 1/15/15 Utilization Review letter states the Knee brace requested on the 1/06/2015 medical report was denied because there was no evidence of knee instability, osteoarthritis, or recent surgery that would warrant it. Unfortunately, the 1/06/2015 medical report was not provided for this review. Only the 10/06/14 neurology report, and 10/29/14

chiropractic report were provided for review, along with the 9/26/14 MRI studies of the right knee, lumbar spine, and right shoulder. There are no reports available from the requesting physician. ACOEM pg 338, table 13-3 Methods of Symptom control for knee complaints, under Options, for meniscal tears, collateral ligament strain, cruciate ligament tear, Immobilizer only if needed. Limited information was provided for this review, but according to the 9/26/14 right knee MRI, the patient does have a torn medial meniscus. MTUS/ACOEM does allow for an immobilizer brace for meniscal tears. Based on the provided information, the Knee Brace IS medically necessary.

**Range of motion testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Range of Motion and Official Disability Guidelines (ODG), Low Back Chapter, Flexibility.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official disability guidelines Lumbar Chapter online, for Flexibility.

**Decision rationale:** The 1/15/15 Utilization Review letter states the ROM testing requested on the 1/06/2015 medical report was denied because AMA guides, require inclinometer testing and computerized testing is not recommended. Unfortunately, the 1/06/2015 medical report was not provided for this review. Only the 10/06/14 neurology report and 10/29/14 chiropractic report were provided for review, along with the 9/26/14 MRI studies of the right knee, lumbar spine, and right shoulder. There are no reports available from the requesting physician. MTUS/ACOEM, chapter 9, shoulder, page 200, under Regional Shoulder Examination states: A shoulder examination includes the neck region as well as the shoulder. Ask the patient to point to the area of discomfort with one finger. The range of motion of the shoulder should be determined actively and passively. The examiner may determine passive ROM by eliminating gravity in the pendulum position or by using the other arm to aid elevation. ODG-TWC guidelines, Lumbar Chapter online, for Flexibility states: Not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. And The AMA Guides to the Evaluation of Permanent Impairment, 5th edition, state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way (p 400). They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value." MTUS/ACOEM and ODG guidelines state ROM testing should be a normal part of the physical examination. It is not necessary to perform the testing as a separate procedure or to use computerized testing. The request for Range of motion testing, as a separate procedure, IS NOT medically necessary.

**Urine toxicology testing:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Steps to Avoid Misuse/Addiction and Opioids, Screening For Risk of Addiction (Tests).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

**Decision rationale:** The 1/15/15 Utilization Review letter states the urine drug screen requested on the 1/06/2015 medical report was denied because the patient's treatment plan did not include narcotic medications, and there was no documentation of suspicion that the patient is using illegal drugs. Unfortunately, the 1/06/2015 medical report was not provided for this review. Only the 10/06/14 neurology report and 10/29/14 chiropractic report were provided for review, along with the 9/26/14 MRI studies of the right knee, lumbar spine, and right shoulder. There are no reports available from the requesting physician. MTUS Chronic Pain Medical Treatment Guidelines, for Drug Testing, pg 43 under Drug testing states: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The medical report that requests or discusses the urine toxicology testing was not available for this review. There is no indication that the patient has had prior urine toxicology testing. MTUS does allow for urine drug screens. Based on the limited information provided, the Urine toxicology testing IS medically necessary.

**Menthoderm cream:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/cdi/menthoder-cream.html>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Topical analgesic Page(s): 105, 111-113.

**Decision rationale:** The 1/15/15 Utilization Review letter states the Menthoder cream requested on the 1/06/2015 medical report was denied because the reviewer believes it is a topical NSAID and MTUS states these are only indicated for knees or elbows or joints amenable to topical treatment. Unfortunately, the 1/06/2015 medical report was not provided for this review. Only the 10/06/14 neurology report and 10/29/14 chiropractic report were provided for review, along with the 9/26/14 MRI studies of the right knee, lumbar spine, and right shoulder. There are no reports available from the requesting physician. Menthoder gel is a compound topical containing methyl salicylate 15% and menthol 10%. This is a salicylate topical. MTUS Chronic Pain Medical Treatment Guidelines, page 105 for Salicylate topicals, states: "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded." The medical report that requests or discusses use of Menthoder was not available for this review. MTUS guidelines appear to support use of salicylate topicals such as Menthoder. The request for Menthoder cream IS medically necessary.