

Case Number:	CM15-0191681		
Date Assigned:	10/05/2015	Date of Injury:	02/15/2015
Decision Date:	12/08/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/29/2015

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: Pennsylvania

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 21 year old male with a date of injury on 2-15-15. A review of the medical records indicates that the injured worker is undergoing treatment for multiple orthopedic symptoms. Progress report dated 8-26-15 reports follow up for right forearm fracture and right femur. He was doing physical therapy and still walks with a cane. He has continued symptoms in his right thigh and right knee and intermittent pain in right forearm and wrist. Objective findings: right wrist has pain on pronation and supination and forceful gripping. Right thigh is tender to palpation over the femur and the patellar facets and patellar tendon, right knee range of motion is 0-140, negative Lachman's, negative drawer, negative varus/valgus stress test and discomfort on McMurrays testing, Right hip with good range of motion. Treatments include: medication, physical therapy (18 sessions) and surgery. Request for authorization was made for menthoderm gel 120 gm, chiropractic 3 times per week for 6 weeks right lower leg, functional capacity evaluation and range of motion testing. Utilization review dated 9-14-15 non-certified the requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm gel 120mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Salicylate topicals.

Decision rationale: This worker has pain at joints amenable to topical analgesics. Methoderm gel contains menthol and methyl salicylate. Topical salicylates are recommended in the MTUS. Menthol is not specifically listed in the MTUS but is a product in [REDACTED] that is specifically discussed under topical salicylates and is recommended. Therefore the request is medically necessary.

Chiro 3x6 right lower leg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: This worker has right thigh and knee pain with discomfort with McMurray's test. Chiropractic has been requested for the right lower leg. Chiropractic is discussed in the MTUS under manual therapy and manipulation. According to the MTUS, manual therapy and manipulation are specifically not recommended for the knee. The request is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation.

Decision rationale: The ACOEM states, "Consider using a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability". This worker has returned to work with modified duties. The record does not establish the necessity of a formal evaluation to determine functional limitations and work capability beyond what has already been determined. Therefore the request is not 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back/Flexibility.

Decision rationale: Range of motion testing using a goniometer is a routine part of musculoskeletal evaluation, routinely performed by physical therapist and others. Neither the MTUS nor the ODG specifically address computerized range of motion testing of the extremities. The ODG does address computerized lumbar spine range of motion and states they do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers. Similarly, upper and lower extremity range of motion testing can be accomplished with a goniometer. The visit note reports measurements of range of motion. There is no medical necessity for computerized range of motion testing or any range of motion testing other than what is performed in routine musculoskeletal evaluation. The request is not medically necessary.