

Case Number:	CM14-0150898		
Date Assigned:	09/19/2014	Date of Injury:	02/29/2012
Decision Date:	12/02/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/16/2014

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 Occupational Medicine, and is licensed to practice in California. 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 55-year-old female with a date of injury 2/29/2012. She is diagnosed with (a) paraplegia, (b) neurogenic bladder, (c) neurogenic bowel, (d) neurogenic impotence, (e) regional osteopenia/osteoporosis, (f) chronic pain syndromes with neuropathic pain components, (g) multiple orthopedic issues, and (h) left ankle swelling post injury - rule out sprain/strain versus non-displaced fracture. She was hit by a tractor and caused broken ribs, damaged kidney, lacerated adrenal gland with T12 injury and subsequent chest tube required and spinal fusion T10-L2. She reported that her right shoulder pain was worse and still painful, constant 3-4/10 and cannot lie on the right shoulder at night. She was not able to do any walking on land but can in the pool. She reported that she experienced new falls since last follow-up but without any injury. She reported that she needed bilateral ankle/foot orthoses to walk with therapy up to 200 feet with 3 breaks using front-wheeled walker. She still placed a lot of weight through her hands when using the walker. With regard to her bilateral knee pain, she reported that it would come and go. She rated left and right medial knee pain as 4-5 up to 7/10. She also reported right leg neuropathic pain rated at 8/10 and stated episodic pains drove her crazy. Right shin remained tender to touch and has intermittent pulsing pains from her right calf to her right shin. She also complained of left shoulder pain that was constant dull annoying and lingering pain that was worse at night. It was aggravated by lying on her shoulder or propelling her wheelchair. She rated the left shoulder pain as 3-4/10. Regarding her left groin and anterior thigh pain which comes and goes rated it at 7-8/10 as worst and 4/10 at best. She also noted band of numbness from lower abdomen to upper thighs were still the same. She also noted that she can only sleep up to 1.5 hours increment then was awakened by pain. She reported that she uses 5 self-catheterization 5 days per day using Rusch MMG H2O catheter 14F volumes 150-900 cc. She reported that she had a bladder stone removed via cystolithotomy. Last urinary tract infection

(UTI) was in May and was treated with Cipro. Objectively, right hip examination noted limited internal rotation. Left ankle pain with passive inversion and swelling without gross ecchymosis over the medial and lateral malleoli. Band of absent sensation T12 right and left T12 - L1 and reported numbness distal to right ankle. Motor was 4/5 right hip flexion, 2-/5 left. Right quad 4+/5 but left 3-/5. Hamstring was 4/5 and 2/5 left. Ankle and toes was 0/5 grossly. A magnetic resonance imaging (MRI) of the right shoulder dated 1/4/2013 noted severe distal anterior supraspinatus tendinosis with a 6 by 7 mm tear, most likely through and through. Type II acromion with enthesopathy of insertion of the thick ended irregular coracoacromial ligament likely representing impingement. A computed tomography (CT) scan of the right hip dated 1/4/2013 noted moderately advanced arthrosis with chronic femoral acetabular impingement and osteoporosis. Greater trochanter mild enthesopathy with probable chronic tendinosis of the gluteus minimus and fatty atrophy muscle belly changes. 1/7/2013 bone density scan noted lumbar spine T -1.5, Z -1.7, and left hip T -3.5, Z -3.3. Left ankle magnetic resonance imaging (MRI) dated 1/7/2013 noted peroneus longus and brevis tendinosis with Type 1 partial tearing and probable longitudinal split tear of peroneus brevis. Denervation changes within muscles of the neck. Plantar calcaneal spur and Achilles insertional enthesopathy. 1/7/2013 left knee magnetic resonance imaging (MRI) scan noted medial meniscus body and posterior horn flap tears and denervation changes within muscles.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of bilateral pressure relief ankle/foot orthosis (PRAFO): Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot, Ankle Foot Orthosis (AFO)

Decision rationale: According to Official Disability guidelines (2013), an ankle foot orthosis is also used during surgical or neurologic recovery. It is also helpful if the foot can achieve plantigrade position when standing as well as if there is ankle instability or spasticity such as injured workers with upper motor neuron diseases. In this case, the injured worker is noted to have suffered from T10 injuries causing paraplegia which is paralysis of the lower extremity. After undergoing certain treatments at this point can be considered as rehabilitation. A pressure relief ankle foot orthosis is a device that is worn on the calf and foot similar to a boot and is often used for injured workers that spend most of their time in bed. It is used to prevent bedsores or ulcers from developing on the back of the heel and it is used to position the foot neutrally which can prevent constant plantar flexion. If position is not changed muscle tightness would develop contractures. When contractures develop, normal range of motion is lost and he or she will not be able to flex the foot upwards. The injured worker is noted to have injured her mid back when a tractor/truck hit her while at work. This consequently caused paraplegia or the impairment of the motor or sensory function of the lower extremities. This consequently caused the injured worker

to lose the functional activity of walking independently or move legs independently. Without the ability to change positions on her lower extremities independently she is at risk of developing pressure sores while lying in bed or leaving lower extremities at constant plantar flexion which can cause contractures. The uses of a bilateral pressure relief ankle/foot orthosis can help maintain dorsiflexion and plantigrade position as well as prevent bed sores. With this clinical presentation, it sufficiently meets the indications as described in Official Disability Guidelines. Based on these reasons, the medical necessity of the requested purchase of bilateral pressure relief ankle/foot orthosis (PRAFO) is established. The utilization review determination noted that there was a mention of the injured worker already having braces that she was using for his ambulation including ankle/foot orthotics, and there was no mention of the injured worker devices having problems and if there were problems with existing devices, no indication as to why these could not be repaired. It would seem that the utilization reviewer mixed up two different ambulation devices from pressure relief ankle/foot orthoses as the requested treatment modality is more of a preventive modality. Therefore, this request is medically necessary.

200 RUSCH MMG H20 14F catheters monthly.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National institute of health

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medical Disability Advisory Fifth Edition Neurogenic Bladder page 1483, The Merck Manual Professional Edition, Neurogenic Bladder, Website:
http://www.merckmanuals.com/professional/genitourinary_disorders/voiding_disorders/neurogenic_bladder.html, Accessed 11/24/2014.

Decision rationale: The injured worker is diagnosed also with neurogenic bladder. Neurogenic bladder is a bladder dysfunction caused by neurologic damage. This is sub-classified into flaccid (hypotonic) and spastic bladder. In this case, the clinical presentation of the injured worker who sustained T10-T12 injuries points out that she has spastic bladder. A spastic bladder is a condition where in the volume of urine are typically normal or small and involuntary contractions occurring. It usually results from brain damage and spinal cord damage above T12. Typical treatment includes catheterization, increased fluid intake and surgery if conservative measures fail. In this case, the injured worker is noted to be doing self-catheterization at least 5 days per day using the above requested durable medical equipment due to spinal cord injury at occurred on 2/29/2012. Conservative treatment including catheterization is initially recommended and can be done intermittently and independently by the injured worker. Since the injured worker's clinical presentation meets the indication for treatment of neurogenic bladder and catheterization is part of conservative treatment, the medical necessity of the requested 200 RUSCH MMG H20 14F catheters monthly is established. The previous utilization review determination noted that there was no clear detail provided as to how many catheters the injured worker has at this point or how much supplies she has at this point. There was also mention that she has a follow-up with an urologist in 3 months. These reasons are noted however if there is disruption with the current supply and authorization takes some time, the condition of the injured worker may worsen before a determination can be made. Physiologic needs comes first in order

to address and prevent any potential comorbidities. Therefore, this request is medically necessary.