

<b>Case Number:</b>	CM14-0151135		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	04/24/2014
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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:

Medical records reflect the claimant is a 50 year old female who sustained a work injury on 4-24-14. The claimant has a history of right foot and ankle injury. Office visit on 4-28-14 notes the claimant has pain lateral and medial aspect of the right ankle. The claimant was provided a diagnosis of ankle sprain/strain, stable. Office visit on 8-6-14 notes the claimant has undergone physical therapy. She had no further care since June 2014. On exam, the claimant ambulates with an antalgic gait, favoring the right lower extremity. There is tenderness to palpation anteriorly/laterally and medially. The claimant has decreased range of motion. DTR are 1+2 at the ankles, decreased motor strength as 4/5. The cm was provided with a prescription for medications, IF unit, hot/cold unit, UDS for medication monitoring.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urine drug screening:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); Drug testing

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ONGOING USE OF OPIOIDS Page(s): 74-96. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER - UDT

**Decision rationale:** Chronic Pain Medical Treatment Guidelines notes under ongoing use of opioids, use of drug screening or inpatient treatment is indicated in patients with issues of abuse, addiction, or poor pain control. There is an absence in documentation noting that this claimant is being prescribed opioids or that she is at high risk for misuse or abuse. Therefore, the medical necessity of this request is not established.

**IF (interferential current stimulation) Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); IF (interferential current stimulation) Unit

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines pain chapter - interferential unit

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that an interferential units are not recommended as a primary treatment modality, but a one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There is an absence in documentation noting that this claimant has had a trial with daily pain diaries noting functional and documented improvement. There is an absence in documentation for this modality as an isolated intervention. Therefore, the medical necessity of this request is not established.

**Hot / Cold Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); Continuous flow cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines foot and ankle chapter cold therapy, continuous flow cryotherapy

**Decision rationale:** ODG notes that regular local application of cold packs is appropriate following acute injury for 24 to 48 hours and with continued swelling. RICE (rest, ice, compression, elevation) is appropriate for first 24 hours for sprain/fracture. (Colorado, 2001) Ice works better than heat to speed recovery. ODG notes that continuous flow cryotherapy is not recommended. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries in the ankle and foot has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Most studies are for the knee; evidence is marginal that treatment with ice and compression is as effective as cryotherapy after an ankle sprain. There is an absence

in documentation noting that this claimant requires specialized equipment for the application of hot or cold therapy. Therefore, the medical necessity of this request is not established.

**FCE (Functional Capacity Evaluation): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines FCE (Functional Capacity Evaluation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines FUNCTIONAL IMPROVEMENT MEASURES. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES PAIN CHAPTER - FUNCTIONAL IMPROVEMENT MEASURES

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that functional improvement measures for chronic pain is used to consider return to normal quality of life. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. There is an absence in documentation noting how the Functional Capacity Evaluation is going to change the course of treatment. The claimant has been TTD for some time now. Therefore, the medical necessity of this request is not established.

**Physical Therapy 2x6 weeks to the right ankle: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES PAIN CHAPTER PHYSICAL THERAPY

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The claimant had been provided with physical therapy in the past. There is an absence in documentation noting that this claimant cannot perform a home exercise program. There are no extenuating circumstances to support physical therapy at this juncture, so far removed from the injury. Therefore, the medical necessity of this request is not established.

**TG Hot 180 grams: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES PAIN CHAPTER TOPICAL ANALGESICS

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG reflect that these medications are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is an absence in documentation noting that this claimant cannot tolerate oral medications or that she has failed first line of treatment. Therefore the medical necessity of this request is not established.

**Omeprazole 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines proton pump inhibitors.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS GI SYMPTOMS.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines notes that PPI are indicated for patients with intermediate or high risk for GI events. There is an absence in documentation noting that this claimant has secondary GI effects due to the use of medications or that she is at an intermediate or high risk for GI events. Therefore, the medical necessity of this request is not established.