

<b>Case Number:</b>	CM14-0086680		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	03/15/2011
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2014

### 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 Medically necessary in Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 40-year-old female with a 3/15/11 date of injury. The mechanism of injury occurred when the patient was climbing down a ladder and injured her right foot. A UR decision dated 6/3/14 refers to a progress report from 5/5/14, which was not provided for review. According to the 5/5/14 report, surgery has been approved for decompression of the tarsal tunnel. The patient's symptoms have not changed and in fact have worsened. Objective findings: severe flatfoot deformity with calcaneal valgus and collapse of medial column, positive Tinel's sign elicited at the posterior tibial nerve, the medial calcaneal nerve, the medial plantar nerve, and the lateral plantar nerve. Diagnostic impression: tarsal tunnel syndrome, lumbosacral neuritis, joint pain of left leg, lumbago, lumbar/lumbosacral disc degeneration. Treatment to date: medication management, activity modification, physical therapy, trigger point injection, lumbar ESI. A UR decision dated 6/3/14 modified the request for the purchase of cryotherapy unit to a seven day rental. Regarding walker, there is insufficient documentation indicating the concurrent authorization of both a walker and crutches. Regarding home health nurse visits, there is insufficient documentation that the patient will require home health services as it is unclear what the patient's condition will be following the procedure. Treatment to date: medication management, activity modification, physical therapy, trigger point injection, lumbar ESI. A UR decision dated 6/3/14 modified the request for the purchase of cryotherapy unit to a seven day rental. Regarding walker, there is insufficient documentation indicating the concurrent authorization of both a walker and crutches. Therefore, a request for crutches was medically necessary and the request for a walker is not medically necessary. Regarding home health nurse visits, there is insufficient documentation that the patient will require home health services as it is unclear what the patient's condition will be following the procedure.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Purchase of Cryotherapy unit:** 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) Knee Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter.

**Decision rationale:** CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. A UR decision dated 6/3/14 certified a 7-day rental of a cryotherapy unit for post-surgical use. Guidelines do not support the purchase of a cryotherapy unit. Therefore, the request for Purchase of Cryotherapy unit was not medically necessary.

### **Walker:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Medicare National Coverage Determinations Manual.

**Decision rationale:** CA MTUS does not address this issue. ODG states that walking aids are recommended. In addition, the Medicare National Coverage Determinations Manual states that Mobility Assistive Equipment is reasonable and necessary for personal mobility deficits sufficient to impair participation in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home. However, according to the UR decision dated 6/3/14, a request for crutches had been medically necessary for post-surgical use. A specific rationale identifying why the patient would require crutches and a walker was not provided. The use of multiple walking aids is not supported by guidelines. Therefore, the request for Walker was not medically necessary.

### **Home Health Nurse Visits Quantity ten (10):** 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

**Decision rationale:** CA MTUS states that home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. There is no documentation provided regarding the post-surgical condition of the patient. It is not known if the patient is homebound or in need of home health services. In addition, it is unclear what type of services would be provided and if they are intended for medical treatment. Therefore, the request for Home Health Nurse Visits Quantity ten (10) was not medically necessary.