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| <b>Case Number:</b>   | CM14-0119192 |                              |            |
| <b>Date Assigned:</b> | 08/06/2014   | <b>Date of Injury:</b>       | 06/18/2013 |
| <b>Decision Date:</b> | 01/27/2015   | <b>UR Denial Date:</b>       | 06/24/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/29/2014 |

### 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 Orthopedic Surgery, has a subspecialty in ENTER SUBSPECIALTY and is licensed to practice in Georgia. 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 66-year-old male who reported an injury of unspecified mechanism on 06/18/2013. On 05/21/2014, his diagnoses included painful internal fixation, status post removal of fixation from the left fibula, status post open reduction and internal fixation of the left medial malleolus/tibia, nonunion medial malleolar fracture with displacement, and painful gait. He demonstrated some moderate improvement regarding his left ankle, and he was ambulating better than previously noted. His complaints included sharp pain on the medial aspect of the ankle joint. There was a well healed incision on the medial aspect of the left foot secondary to ORIF. The skin temperature, tone, and color were within normal limits. All epicritic sensations were intact and symmetrical bilaterally. X-rays of the medial malleolus were taken, which demonstrated complete healing of the malleolus with some retraction of the internal fixation. He also had mild degenerative joint disease and loss of cartilaginous height of the ankle. There was no rationale or Request for Authorization included in this injured worker's chart.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME purchase: hot/cold therapy IF unit.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back (updated 06/10/14)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

**Decision rationale:** The request for DME purchase: hot/cold therapy IF unit is not medically necessary. The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise, and medications. The randomized control trials that have evaluated the effectiveness of this treatment have included studies for back, jaw, soft tissue shoulder, cervical neck, and postoperative knee pain. Although it has been proposed for treatment in general for soft tissue injury or for enhanced wound or fracture healing, there was insufficient literature to support interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy. The therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode placement technique. Additionally, the body part or parts to which this interferential unit was to have been applied were not specified, nor were there any parameters for frequency of stimulation, pulse duration, treatment time, or electrode placement. Therefore, this request for DME purchase: hot/cold therapy IF unit is not medically necessary.

**Knee 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 ; Knee and Leg (updated 06/05/14) Ankle & Foot (updated 3/26/14) Walking aids (canes, crutches, Braces orthoses and walkers)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG), Knee & Leg, Durable medical equipment (DME), Walking aids.

**Decision rationale:** The request for knee walker is not medically necessary. In the Official Disability Guidelines, durable medical equipment (DME) is recommended generally if there is a medical need and if the device or system meets Medicare's definition of DME, defined as equipment which can withstand repeated use for example, could normally be rented and used by successive patients, and is primarily and customarily used to serve a medical purpose. Assistive devices for ambulation can reduce pain associated with osteoarthritis. Framed or wheeled walkers are preferable for patients with bilateral osteoarthritis. There was no pathology of the knee described in the submitted documentation. There was no evidence of bilateral osteoarthritis. The need for this piece of equipment was not clearly demonstrated in the submitted documentation. Therefore, this request for knee walker is not medically necessary.

**Shower boot.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Durable medical equipment (DME).

**Decision rationale:** The request for shower boot is not medically necessary. In the Official Disability Guidelines, durable medical equipment (DME) is recommended generally if there is a medical need and if the device or system meets Medicare's definition of DME, defined as equipment which can withstand repeated use for example, could normally be rented and used by successive patients, and is primarily and customarily used to serve a medical purpose. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. It was noted that this injured worker's ankle was well healed after his surgery. There was no justification for needing a shower boot. Therefore, this request for shower boot is not medically necessary.

**Post op PT 3x4 weeks.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10.

**Decision rationale:** The request for postop PT 3x4 weeks is not medically necessary. In the California MTUS Post-Surgical Treatment Guidelines, the initial course of postoperative therapy means one half of the number of visits specified in the general course of therapy for the specific surgery performed. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. Therefore, this request for postop PT 3x4 weeks is not medically necessary.

**IF 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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

**Decision rationale:** The request for IF unit is not medically necessary. The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise, and medications. The randomized control trials that have evaluated the effectiveness of this treatment have included the studies for back, jaw, soft tissue shoulder, cervical neck, and postoperative knee pain. Although it has been proposed for treatment in general for soft tissue injury or for enhanced wound or fracture healing, there was insufficient literature to support interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy. The

therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode placement technique. Additionally, the body part or parts to which this interferential unit was to have been applied were not specified, nor were there any parameters for frequency of stimulation, pulse duration, treatment time, or electrode placement. Therefore, this request for IF unit is not medically necessary.