

Case Number:	CM15-0148995		
Date Assigned:	08/14/2015	Date of Injury:	01/07/2015
Decision Date:	09/14/2015	UR Denial Date:	07/20/2015
Priority:	Standard	Application Received:	07/31/2015

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: California, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic Surgery

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 53 year old male, who sustained an industrial injury on 01-07-2015 secondary to a fall resulting in pilon fracture of the distal left tibia. On provider visit dated 07-10-2014 the first page and dated 07-10-2015 on the 2nd and 3rd page, the injured worker has reported improvement in left ankle symptoms, increased pain in right ankle, left shoulder and undergoing chiropractic treatment for lower back. On examination of the injured worker was noted to walk with a slight antalgic gait. Left ankle was noted as the swelling was better and range of motion was improved. Tenderness over the head of the screw on the medial side of the malleolus was noted. Lumbar spine was noted as having tenderness to palpation over the the paravertebral muscle area. And left shoulder revealed pain with range of motion of the left shoulder. Positive impingement sign and rotator cuff strength was 4 out of 5. The diagnoses have included left ankle fracture complex status post open reduction-internal fixation-healed, symptom at screw left ankle, left shoulder partial rotator at cuff tear and impingement, low back pain with disc bulges and right ankle tendinitis. The injured worker was noted to be temporarily totally disabled. Treatment to date has included medication, left shoulder cortisone injection, physical therapy and chiropractic therapy. The injured worker underwent open reduction internal fixation left ankle distal fibular fracture with plate and screws and bone grafting on 01-07-2015. The provider requested removal of hardware (ankle-foot), pain management-epidural injection lumbar spine, chiropractic treatment-lumbar spine-2 times weekly for 4 weeks-8 sessions and physical therapy-left shoulder-2 times weekly for 6 weeks-12 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Removal of Hardware (ankle/foot): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Ankle & Foot (Acute & Chronic).

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

Decision rationale: According to the ODG Ankle and Foot, Hardware implant removal, "Not recommend the routine removal of hardware implanted for fracture fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection." In this case other causes of continued pain such as infection and non-union have not been ruled out. The request is not medically necessary.

Pain Management, Epidural Injection, Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural Page(s): 46.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 46, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In addition, there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case the exam notes cited do not demonstrate a failure of conservative management nor a clear evidence of a dermatomal distribution of radiculopathy. Therefore, the request is not medically necessary.

Chiropractic treatment, Lumbar Spine, 2 times wkly for 4 wks, 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy Page(s): 58.

Decision rationale: Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, Manual therapy and manipulation, page 58, chiropractic care is recommended as an option with a trial of 6 visits over 2 weeks with evidence of objective functional improvement, with a total of up to 18 visits over 6-8 weeks. In this case the request exceeds the 6 visits and therefore the request is not medically necessary.

Physical Therapy, Left Shoulder, 2 times wkly for 6 wks, 12 sessions: Overtuned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks, Postsurgical physical medicine treatment period: 6 months. The guidelines recommend "initial course of therapy" to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. In this case the request is in keeping with guidelines and is medically necessary.