

Case Number:	CM15-0198844		
Date Assigned:	10/14/2015	Date of Injury:	12/05/2012
Decision Date:	11/23/2015	UR Denial Date:	09/12/2015
Priority:	Standard	Application Received:	10/09/2015

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: Illinois, California, Texas
 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:

This injured worker is a 30-year-old male who sustained an industrial injury on 12/5/12. Injury occurred while he was climbing a ladder from a first to second floor roof and the ladder slipped backwards. He fell off the ladder 5 feet onto the first roof, rolled and fell 10 feet off the first roof onto the ground below. His left leg struck the ground first, bending inward. He sustained a left ankle pilon fracture. He underwent open reduction and internal fixation on 12/19/12, and subsequent open reduction and internal fixation of non-union of the left tibia pilon fracture on 1/9/15. The 7/29/15 treating physician report cited persistent left ankle pain. There was temporary pain reduction but no change in range of motion with physical therapy. First line medications only controlled pain temporarily and to a small extent. Topical medications had been recommended. Physical exam documented well-healed surgical incision, normal vascular exam, and significant exostoses at the distal tibia, causing inability to dorsiflex the ankle. The neurological exam was intact. Muscle testing was within normal limits. He was unable to ambulate normally due to 0 degrees of dorsiflexion past the weight-bearing perpendicular position. The treatment plan recommended an exostectomy of the tibia of the left ankle. Authorization was requested for a hot and cold therapy, interferential unit, and a knee walker for postoperative care. The 9/12/15 utilization review non-certified the request for hot/cold therapy as continuous flow cryotherapy was not guideline-supported in the ankle. The request for interferential unit was non-certified as there was no indication that the injured worker would be unable to perform post-operative physical therapy due to pain. The request for a knee walker was non-certified as there was no evidence that the injured worker would require this level of assistive device versus other simpler aids.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: hot/cold therapy: 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.

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot: Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding hot/cold therapy units, but support at home applications of cold or heat packs. The Official Disability Guidelines state that continuous flow cryotherapy is not recommended in ankle complaints. Guidelines support the use of applications of cold packs and heat. This request is for a cold therapy unit for unknown length of use is not consistent with guidelines. There is no compelling rationale presented to support this request as an exception to guidelines. Therefore, this request is not medically necessary.

Associated surgical service: IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The California MTUS guidelines do not recommend interferential current (IFC) stimulation as an isolated intervention. Guidelines indicate that a one-month IFC trial may be indicated for post-operative conditions if there is significant pain that limits the ability to perform exercise programs/physical therapy treatment. Guideline criteria have not been met. There is no indication that the patient will be unable to perform post-op physical therapy exercise or treatment, or that post-operative pain management will be ineffective. Additionally, this request for an unspecified duration of use is not consistent with guidelines. Therefore, this request is not medically necessary.

Associated surgical service: 1 knee walker: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot: Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The California MTUS guidelines do not provide specific guidelines for post-op ambulatory assistant devices. The Official Disability Guidelines recommend the use of walking aides (cane, crutches, braces, orthoses, and walkers) for patients with conditions causing impaired ambulation, when there is a potential for ambulation with these devices. Guideline

criteria have been met. This patient has been certified for left foot surgery. The use of a standard knee walker to facility mobility is consistent with guidelines. Therefore, this request is medically necessary.