

<b>Case Number:</b>	CM15-0052508		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	01/16/2014
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 44 year old male, who sustained an industrial injury on January 16, 2014. The injured worker had reported a left foot injury. The diagnoses have included partial amputations of the left third and fourth toes, crush injury to the left third and fourth toes, hypertrophic scar of the planter aspect of the left third toe, painful gait and lumbar spine sprain/strain due to favoring and an antalgic gait. Treatment to date has included medications, radiological studies, physical therapy and left foot surgery. Current documentation dated January 26, 2015 notes that the injured worker reported left foot pain at the fifth metatarsal and in the third toe. He also noted difficulty with his gait. Physical examination of the left foot revealed pain with palpation, painful function of the foot and a poor gait. The injured worker also was noted to have a hypertrophic scar on the planter aspect of the third toe, which created difficulty with squatting, crouching and pushing off on the foot. The treating physician's plan of care included requests for a knee walker, hot/cold therapy unit and a controlled ankle motion walker.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Knee Walker:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 361-386.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Walking aids (canes, crutches, braces, orthoses, & walkers). <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, walking aids (canes, crutches, braces, orthoses, & walkers) "Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanical load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals. (Reeves, 2011) See also U-Step walker." The patient left foot injury for which he underwent a third and fourth toes amputation. There is no documentation that the patient suffered a knee damage that will require a walker. Therefore, the request for knee walker is not medically necessary.

**Hot/ Cold Therapy 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: Ankle & Foot Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.?([http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#SPECT](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT)).

**Decision rationale:** According to ODG guidelines, cold therapy is "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel". There is no evidence to support the efficacy of hot and cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. There are no controlled studies supporting the use of hot/cold therapy in chronic knee and ankle pain. Therefore, the request for hot/cold therapy unit is not medically necessary.

**CAM (Controlled Ankle Motion) Walker:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 361-386.

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

**Decision rationale:** According to ODG guidelines, Cast (immobilization) Not recommended in the absence of a clearly unstable joint or a severe ankle sprain. Functional treatment appears to be the favorable strategy for treating acute ankle sprains when compared with immobilization. Partial weight bearing as tolerated is recommended. However, for patients with a clearly unstable joint, immobilization may be necessary for 4 to 6 weeks, with active and/or passive therapy to achieve optimal function. (Kerkhoffs-Cochrane, 2002) (Shrier, 1995) (Colorado, 2001) In young patients with low-risk ankle fractures, treatment with a removable ankle brace leads to greater activity level and faster return to baseline activity level vs. treatment with a cast, and the removable ankle brace is also more cost-effective and preferred by more patients than treatment with a cast. (Boutis, 2007) A 10-day period of immobilization in a below-knee cast or Aircast results in a more rapid recovery from severe ankle sprain compared with the current clinical practice of mobilization after a severe ankle sprain according to an RCT in The Lancet. The researchers conclude that below-knee cast is a better choice for clinicians treating severe ankle sprains than a tubular compression bandage because it aids recovery, lessens symptoms, and

helps patients return to normal function. The results of the study call into question the current standard of aggressive functional treatment of patients recovering from acute ankle sprains. (Lamb, 2009) According to this systematic review of treatment for ankle sprains, for severe ankle sprains, a short period of immobilization in a below-knee cast or pneumatic brace results in a quicker recovery than tubular compression bandage alone. (Seah, 2011) For patients with temporary artificial functional limb length discrepancy (LLD) sequelae from use of a CAM immobilization device, a temporary lift (e.g., a device designed to attach to the contralateral shoe to compensate for the boot-induced functional LLD) can produce a more normal gait by eliminating the functional LLD and avoiding the symptoms commonly associated with a LLD. It is not necessary to put a CAM walker on an uninjured leg to correct the LLD when the injured leg is in such a device. (Song, 2009) See also Immobilization; & Limb length temporary adjustment device". There is no documentation that the patient suffered a severe ankle sprain or an unstable joint. Therefore, the request for CAM walker is not medically necessary.