

<b>Case Number:</b>	CM15-0083486		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	07/20/2000
<b>Decision Date:</b>	06/08/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 42 year old male, who sustained an industrial injury on 07/20/2000. He has reported injury to the neck, right shoulder, and right lower extremity. The diagnoses have included sprain/strain of the cervical spine; impingement syndrome of the right shoulder; status post electrocution; and below the knee amputation, right leg. Treatments have included medications, diagnostics, and surgical intervention. Medications have included Norco, Naproxen, Zanaflex, and Prilosec. A progress note from the treating physician, dated 04/06/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of pain in the neck, right shoulder, and right leg/stump; pain is rated 0-3/10 with the use of medication, and pain is rated 4-6/10 without medications; improvement with activities of daily living as a result of his current medication usage; and needs gel liner and stump sock replacements for his prosthesis, as the foot has now worn through the bottom and the foot/ankle pivot is wearing out. Objective findings included decreased grip strength on the right; right below knee stump is soft without drainage or lesions; walks with an obvious antalgic gait; and the prosthesis has audible click and noise at the ankle/foot pivot, and the sole of the foot has worn through. The plan of treatment has included the request for gel liner x 4 for current prosthesis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gel liner x4:** Overturned

**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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Prostheses (artificial limb).

**Decision rationale:** Recommended as indicated below. A prosthesis is a fabricated substitute for a missing body part. Lower limb prostheses may include a number of components, such as prosthetic feet, ankles, knees, endoskeletal knee-shin systems, socket insertions and suspensions, lower limb-hip prostheses, limb-ankle prostheses, etc. See also Microprocessor-controlled knee prostheses. Criteria for the use of prostheses: A lower limb prosthesis may be considered medically necessary when: 1. The patient will reach or maintain a defined functional state within a reasonable period of time; 2. The patient is motivated to ambulate; and 3. The prosthesis is furnished incident to a physician's services or on a physician's order. Prosthetic knees are considered for medical necessity based upon functional classification, as follows: (a) A fluid or pneumatic knee may be considered medically necessary for patients demonstrating a functional Level 3 (has the ability or potential for ambulation with variable cadence, typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion), or above. (b) A single axis constant friction knee and other basic knee systems are considered medically necessary for patients demonstrating a functional Level 1 (has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator), or above. (c) A high-activity knee control frame is considered medically necessary for patients whose function level is 4. (has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete), or above. (d) Microprocessor-controlled leg prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, and Ossur Rheo Knee) are considered medically necessary in otherwise healthy, active community ambulating adults (18 years of age or older) demonstrating a functional Level 3, or above, with a knee disarticulation amputation or a trans-femoral amputation from a non-vascular cause (usually trauma or tumor) for whom this prosthesis can be fitted and programmed by a qualified prosthetist trained to do so. (Sansam, 2009) Gel liner replacements are necessary for a prosthetic. The gel liners need to be replaced on a regular basis. As such, the request for Gel liner x4 is medically necessary.