

Case Number:	CM14-0141173		
Date Assigned:	09/10/2014	Date of Injury:	04/24/2014
Decision Date:	10/27/2014	UR Denial Date:	08/06/2014
Priority:	Standard	Application Received:	09/02/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 49 year old female who had a work related injury on 04/24/14. The injured worker was on top of a stairway when she accidentally rolled her right ankle and fell downstairs. She felt an immediate onset of pain in her right ankle. She reported the injury to her manager and then reported the injury to the upper management. She was sent home and later contacted for an appointment on the same day at the company clinic. There she was evaluated, x-rays were taken of her right ankle, medication was prescribed, and she was scheduled for a course of physical therapy. She was last seen by the company physician in late June of 2014. No further care was received. Presently, the injured worker is off work and states that her symptoms persist and have not improved and she now presents to this facility seeking further medical care. Medical record dated 08/06/14 the injured worker is complaining of right ankle pain. Physical examination, reveals she ambulates with an antalgic gait favoring the right lower extremity, right ankle tenderness to palpation anteriorly, laterally, medially, decreased range of motion, positive talar tilt test, right foot tenderness to palpation over the plantar aspect, decreased DTR bilateral knees and ankles at 1+ to 2+. Decreased motor strength at the right ankle at 4/5. Diagnoses right ankle sprain/strain, rule out ankle internal derangement. Treatment rendered was prescription was given for TG Hot 180 grams; Omeprazole 20mg #60, interferential unit and hot and cold unit, urine toxicology was administered for medication monitoring. Authorization is formally being requested for physical performance functional capacity evaluation; a physical is requested to ensure this injured worker can safely meet the physical demands of her occupation. Prior utilization review dated 08/06/14 the chiropractic three times a week for four weeks is modified for six visits. There is no further documentation that the injured worker has completed those 6 visits that were certified in August of 2014. The current request is for interferential current stimulation device and monthly supplies, Motorized cold therapy unit with hot and cold pad and

assembly strap, a Urine drug screen, FCE, MRI/MRA of the right ankle and chiropractic 3 x a week for 4 weeks for a total of 12 visits and medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Interferential current stimulation Device and monthly supplies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Interferential current stimulation

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116-123.

Decision rationale: The request for IF Interferential current stimulation Device and monthly supplies is not medically necessary. The guidelines do not support the request; there is no documentation of a trial of 30 days. Therefore medical necessity has not been established.

Motorized cold therapy unit with hot/cold pad and assembly strap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and foot chapter, Continuous-flow cryotherapy

Decision rationale: The request for Motorized cold therapy unit with hot/cold pad and assembly strap is not medically necessary. The guidelines do not recommend. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries in the ankle and foot has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Most studies are for the knee; evidence is marginal that treatment with ice and compression is as effective as cryotherapy after an ankle sprain. As such, medical necessity has not been established.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: As noted on page 43 of the Chronic Pain Medical Treatment Guidelines drug testing is recommended as an option. It is noted that using a urine drug screen to assess for the use or the presence of illegal drugs is an option. Urine drug screens are recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. As such, the request for Urine Drug Screen is not medically necessary.

FCE Functional Improvement measures: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Fitness for Duty Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for duty, Functional capacity evaluation (FCE)

Decision rationale: The request for FCE Functional Improvement measures is not medically necessary. There is no clinical documentation indicating that case management is hampered by complex issues. Injuries that require detailed exploration of workers abilities. Therefore, medical necessity has not been established.

MRI/MRA of the right ankle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Foot and ankle

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Foot and ankle chapter, Magnetic resonance imaging (MRI)

Decision rationale: The request for MRI/MRA of the right ankle is not medically necessary. The clinical documentation of subjective complaints and tenderness to palpation and pain with range of motion, there is no documentation of diagnosis for which MRI is indicated. Therefore medical necessity has not been established.

Chiropractor three times a week for four weeks (12 total): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Manipulation for the low back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 59.

Decision rationale: The request for Chiropractor three times a week for four weeks (12 total) is not medically necessary. Prior utilization review dated 08/06/14 the chiropractic 3 x a week for 4 weeks is modified for 6 visits. There is no further documentation that the injured worker has completed those 6 visits that were certified in August of 2014. If the injured worker did complete the 6 visits there is no documentation of functional improvement. Therefore, medical necessity has not been established.