

Case Number:	CM15-0111152		
Date Assigned:	06/17/2015	Date of Injury:	06/18/2013
Decision Date:	08/18/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	06/09/2015

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 67-year-old male who sustained an industrial injury on 6/18/13. Injury occurred when a motorcycle fell on him, landing on his left ankle. He underwent open reduction and internal fixation of the left medial malleolus/tibia fracture on 7/17/13, removal of fixation of the left medial malleolus 8/01/14, and debridement of wound to bone in the left ankle 9/05/14. The 3/2/15 left ankle MRI revealed an incompletely united distal fibular fracture status post hardware removal in stable alignment. There was a healed posterior malleolar fracture with residual articular surface irregularity and mild marrow signal alteration at the fracture site, post traumatic tibiotalar joint osteoarthritis with high grade chondral loss and cystic change of the tibial plafond laterally, and post-surgical change at the medial malleolar tip compatible with prior deltoid ligament repair. Findings documented chronic syndesmotic and anterior talofibular ligament injury. The 3/25/15 treating physician report cited persistent significant left ankle pain. Physical exam documented pain over the posterior ankle joint, normal neurologic exam, and 5/5 ankle strength. He had continued difficulty with range of motion, particularly plantar flexion, and functional difficulty with weight bearing, especially descending stairs. He had resolution and completion of the fibular and medial malleolar fracture, but there was irregularity. All conservative treatment had been attempted, including injection therapy, physical therapy, immobilization, as well as open reduction and internal fixation and removal of the fixation. Authorization was requested for arthroscopic surgery with debridement of the left ankle, a front wheeled walker, post-operative physical therapy 3 x 4, shower boot, IF unit, and cold therapy unit. The 5/6/15 utilization review certified the request for left ankle arthroscopic debridement,

post-operative physical therapy 3x4, and front wheeled walker. The request for crutches was non-certified as there was no documented that a second ambulatory aide was needed or that the certified front wheeled walker would be insufficient for home use. The request for a cold therapy unit was non-certified as there was no compelling reason to support a cold therapy unit over standard cold packs. The request for an IF unit was non-certified as there was limited evidence to suggest the injured worker would be unable to tolerate an exercise program or had failed post-operative conservative care. The request for a shower boot was non-certified as there was no indication why this claimant requires the use of a specialized shower boot instead of the standard way to keep it dry.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: crutches: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Ankle & Foot Procedure Summary Online Version.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371-372. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The California MTUS guidelines support the use of crutches for partial weight bearing for patients with knee complaints. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The post-operative use of crutches is consistent with guidelines. Therefore, this request is medically necessary.

Associated surgical service: cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Ankle & Foot Procedure Summary Online Version.

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: Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous flow cryotherapy is not recommended in ankle complaints. Guidelines support the use of applications of cold packs. This request is for a cold therapy unit for unknown length of use is not consistent with guidelines. Therefore, this request for one cold therapy unit is not medically necessary.

Associated surgical service: IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

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: shower boot: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Procedure Summary Online Version.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg: Durable medical equipment (DME).

Decision rationale: The California MTUS guidelines do not provide recommendations for this item. The Official Disability Guidelines state that certain toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Guidelines state that most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of this request, other than as a patient convenience item. Therefore, this request is not medically necessary.