

Case Number:	CM15-0113526		
Date Assigned:	06/19/2015	Date of Injury:	12/28/2014
Decision Date:	07/21/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/12/2015

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, Alabama, 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 53 year old female, who sustained an industrial injury on December 28, 2014. An MRI of the right foot on January 7, 2015 revealed an acute comminuted fracture of the head and neck of the talus and possible contusion and/or non-displaced fracture of the navicular. An MRI of the right ankle confirmed the acute comminuted fracture of the head and neck of the talus and revealed slight articular depression of the posterior subtalar joint compatible with osteochondral injury, acute tear of the anterior talofibular ligament, probable partial tear of the deltoid ligament, mild contusion of the distal tibiofibular joint, interstitial tear of the peroneus brevis tendon and mild distal Achilles tendinosis. Treatment to date has included medications, orthotics, diagnostic imaging, open reduction and internal fixation of right talar neck fracture and fixation of right talar head with headless screws, home exercises, and work restrictions. Currently, the injured worker reports minimal discomfort three and a half months post-operative open reduction and internal fixation. On physical examination she has 12 degrees of ankle dorsiflexion, 4 degrees of plantar flexion, 30 degrees of eversion and 5 degrees of inversion. She reports minimal tenderness over the ankle and has mild swelling. The diagnoses associated with the request include status post open reduction and internal fixation of the right talus and left knee pain. The treatment plan includes Neoprene brace, twelve sessions of physical therapy for the right ankle and follow-up evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x week x 6 weeks right ankle: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)" In this case, the frequency of the treatment should be reduced from 12 to 3 or less sessions. More sessions will be considered when functional and objective improvement are documented. Therefore, the request for Physical Therapy 2x week x 6 weeks right ankle is not medically necessary.