

Case Number:	CM15-0117996		
Date Assigned:	06/26/2015	Date of Injury:	01/27/2015
Decision Date:	08/25/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	06/18/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 27 year old male who sustained an industrial injury on 01/27/2015 when he was hit from behind by a forklift and the forklift ran over his right leg. The injured worker was diagnosed with crush injury to the right lower extremity and lumbar sprain/strain with anterior spondylolisthesis of L5-S1. The injured worker underwent open reduction internal fixation of the right distal tibia and fibula followed by two consecutive surgeries on April 2, 2015 and April 6, 2015 for debridement and skin graft secondary to infection and ulcer formation. The injured worker received live-in rehabilitation with physical therapy, occupational therapy, intravenous antibiotics and dressing changes. Treatment to date has included diagnostic testing, surgery, assistive devices including wheelchair and spring-loaded moon boot, physical therapy, occupational therapy, psychiatric evaluation and treatment and medications. According to the primary treating physician's progress report on June 4, 2015, the injured worker continues to experience right leg, knee, ankle and low back pain. The injured worker reports intermittent back pain that radiates to both hips with stiffness. The injured worker was able to weight bear approximately 50% and continues to have open wounds and sores on the right leg that are clean and granulating. The examination of the right knee demonstrated weakness against resistance in flexion with significant hamstring atrophy. Flexion was noted at 90 degrees and extension -5 degrees. Examination of the right foot revealed areas of compromised soft tissue over the subcutaneous border of the tibia extending to the hamstring insertion on the medial side of the calf. There was only slight motion in dorsi and plantar flexion of the right ankle and no active inversion or eversion. The dorsalis pedis pulse and sensation were intact. Current medication is listed as Percocet. Treatment plan consists of custom

right boot orthotics, continue psychologist/psychiatrist follow-up and treatment, aggressive wound debridement, ambulation training and the current request for six month rental of manual wheelchair 20"x18", six month rental of right elevated leg rest for wheelchair, six month rental of left elevated leg rest for wheelchair and one tub transfer bench.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Months rental of right elevated leg rest for wheelchair: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Knee and Leg.

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 chapter, under Wheelchair.

Decision rationale: The patient presents on 06/04/15 with unrated lower back pain, right knee pain, right ankle pain, and diffuse pain throughout the right lower extremity. The patient's date of injury is 01/27/15. Patient is status post open reduction and internal fixation of the tibia and fibula following crush injury. The request is for 6 Months rental of right elevated leg rest for wheelchair. The RFA was not provided. Physical examination dated 06/04/15 reveals intact bandaging on the right leg from the knee to the foot. The provider notes a well healed incision over the medial malleolus, a long fibular incision, several areas of compromised soft tissue over the subcutaneous border of the tibia extending to the hamstring insertion on the medial calf. There is an open incision extending from the mid-popliteal area to the distal fibula along the lateral border of the gastrocnemius. The patient is currently prescribed Norco. Diagnostic imaging included in-office radiographs dated 06/04/15, demonstrating fixation hardware with multiple plates and screws in place on the Tibia and Fibula. Patient is currently classified as temporarily totally disabled. ODG Knee and Leg chapter, under Wheelchair has the following: "Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Reclining back option recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day. Elevating leg rest option recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has significant edema of the lower extremities. Adjustable height armrest option recommended if the patient has a need for arm height different than that of available using non-adjustable arms. A lightweight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair, and the patient would be able to self-propel in the lightweight wheelchair." In regard to the six month rental of an elevated leg rest for this patient's wheelchair, the request is appropriate. This patient presents with significant injury and deformity of the right lower extremity following traumatic crush injury. It is noted by the provider that this patient has required (and will continue to require) significant medical treatment directed at this injury. Given the severity and ongoing nature of this patient's condition, a six month rental of a

wheelchair and the associated accessories is a necessary and appropriate measure. Therefore, the request is medically necessary.

6 Months rental of left regular leg rest for wheelchair: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Knee and Leg.

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 chapter, under Wheelchair.

Decision rationale: The patient presents on 06/04/15 with unrated lower back pain, right knee pain, right ankle pain, and diffuse pain throughout the right lower extremity. The patient's date of injury is 01/27/15. Patient is status post open reduction and internal fixation of the tibia and fibula following crush injury. The request is for 6 Months rental of left regular leg rest for wheelchair. The RFA was not provided. Physical examination dated 06/04/15 reveals intact bandaging on the right leg from the knee to the foot. The provider notes a well healed incision over the medial malleolus, a long fibular incision, several areas of compromised soft tissue over the subcutaneous border of the tibia extending to the hamstring insertion on the medial calf. There is an open incision extending from the mid-popliteal area to the distal fibula along the lateral border of the gastrocnemius. The patient is currently prescribed Norco. Diagnostic imaging included in-office radiographs dated 06/04/15, demonstrating fixation hardware with multiple plates and screws in place on the Tibia and Fibula. Patient is currently classified as temporarily totally disabled. ODG Knee and Leg chapter, under Wheelchair has the following: "Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Reclining back option recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day. Elevating leg rest option recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has significant edema of the lower extremities. Adjustable height armrest option recommended if the patient has a need for arm height different than that of available using non-adjustable arms. A lightweight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair, and the patient would be able to self-propel in the lightweight wheelchair." In regard to the six month rental of a leg rest for this patient's wheelchair, the request is appropriate. This patient presents with significant injury and deformity of the right lower extremity following traumatic crush injury. It is noted by the provider that this patient has required (and will continue to require) significant medical treatment directed at this injury. Given the severity and ongoing nature of this patient's condition, a six month rental of a wheelchair and the associated accessories is a necessary and appropriate measure. Therefore, the request is medically necessary.

1 Tub transfer bench: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Knee and Leg.

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 chapter, under Wheelchair.

Decision rationale: The patient presents on 06/04/15 with unrated lower back pain, right knee pain, right ankle pain, and diffuse pain throughout the right lower extremity. The patient's date of injury is 01/27/15. Patient is status post open reduction and internal fixation of the tibia and fibula following crush injury. The request is for 1 tub transfer bench. The RFA was not provided. Physical examination dated 06/04/15 reveals intact bandaging on the right leg from the knee to the foot. The provider notes a well healed incision over the medial malleolus, a long fibular incision, several areas of compromised soft tissue over the subcutaneous border of the tibia extending to the hamstring insertion on the medial calf. There is an open incision extending from the mid-popliteal area to the distal fibula along the lateral border of the gastrocnemius. The patient is currently prescribed Norco. Diagnostic imaging included in-office radiographs dated 06/04/15, demonstrating fixation hardware with multiple plates and screws in place on the Tibia and Fibula. Patient is currently classified as temporarily totally disabled. ODG-TWC guidelines, Knee Chapter online for DME states: Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. (CMS, 2005) In regard to the tub transfer bench for this patient to use in his home, the request is appropriate. This patient presents with significant and ongoing complications following a traumatic crush injury to the right lower extremity, and as a result experiences significant difficulty ambulating and weight-bearing. The requested bench fits ODG criteria in that it can withstand repeated use, is primarily used to serve a medical purpose, is not useful in the absence of injury, and is designed for use in the patient's home. Given the nature of this patient's injury, a tub transfer bench is an appropriate medical intervention. Therefore, the request is medically necessary.

6 Months rental of manual wheelchair 20" x 18": Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Knee and Leg.

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 chapter, under Wheelchair.

Decision rationale: The patient presents on 06/04/15 with unrated lower back pain, right knee pain, right ankle pain, and diffuse pain throughout the right lower extremity. The patient's date of injury is 01/27/15. Patient is status post open reduction and internal fixation of the tibia and fibula following crush injury. The request is for 6 Months rental of manual wheelchair 20" X 18". The RFA was not provided. Physical examination dated 06/04/15 reveals intact bandaging on the right leg from the knee to the foot. The provider notes a well healed incision over the medial malleolus, a long fibular incision, several areas of compromised soft tissue over the

subcutaneous border of the tibia extending to the hamstring insertion on the medial calf. There is an open incision extending from the mid-popliteal area to the distal fibula along the lateral border of the gastrocnemius. The patient is currently prescribed Norco. Diagnostic imaging included in-office radiographs dated 06/04/15, demonstrating fixation hardware with multiple plates and screws in place on the Tibia and Fibula. Patient is currently classified as temporarily totally disabled. ODG Knee and Leg chapter, under Wheelchair has the following: "Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Reclining back option recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day. Elevating leg rest option recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has significant edema of the lower extremities. Adjustable height armrest option recommended if the patient has a need for arm height different than that of available using non-adjustable arms. A lightweight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair, and the patient would be able to self-propel in the lightweight wheelchair." In regard to the six month rental of a standard wheelchair, the request is appropriate. This patient presents with significant injury and deformity of the right lower extremity following traumatic crush injury. It is noted by the provider that this patient has required (and will continue to require) significant medical treatment directed at this injury. Given the severity and ongoing nature of this patient's condition, a six month rental of a wheelchair and the associated accessories is a necessary and appropriate measure. Therefore, the request is medically necessary.