

<b>Case Number:</b>	CM15-0125547		
<b>Date Assigned:</b>	07/10/2015	<b>Date of Injury:</b>	09/26/2014
<b>Decision Date:</b>	08/06/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 67 year old male with an industrial injury dated 09/26/2014. The injured worker's diagnoses include sprain right ankle fracture status post open reduction internal fixation (ORIF) x2, post-operative infection and diabetes mellitus. Treatment consisted of diagnostic studies, prescribed medications, physical therapy and periodic follow up visits. In a progress note dated 05/04/2015, the injured worker presented for evaluation of status post right ankle fracture with post-operative infection. Objective findings revealed swelling and tenderness of the right ankle. Treatment plan consisted of further evaluation and treatment with specialist. The treating physician prescribed services for post-operative electrical stimulation (unattended), 3 times a week, right ankle, per 06/10/15 order Qty: 12, post-operative therapeutic exercises, 3 times a week, right ankle, per 06/10/15 order Qty: 12 and post-operative massage, 3 times a week, right ankle, per 06/10/15 order Qty: 12 now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative electrical stimulation (unattended), 3 times a week, right ankle, per 06/10/15 order Qty: 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 13.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

**Decision rationale:** The California chronic pain medical treatment guidelines section on transcutaneous electrical nerve stimulation states: TENS, chronic pain (transcutaneous electrical nerve stimulation): Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. (Carroll-Cochrane, 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single-dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured. This treatment option is recommended as an adjunct to a program of evidence based functional restoration. However the request is for post-operative use. The documentation indicates the surgery has been denied and therefore this service is not medically necessary and denied.

**Post-operative therapeutic exercises, 3 times a week, right ankle, per 06/10/15 order Qty: 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 13.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: 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) Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less) plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The California MTUS does recommend post-operative physical therapy. However, the provided clinical documentation indicates that repeat surgery has been denied for the ankle and therefore post-operative physical therapy would not be necessary and therefore the request is not medically necessary.

**Post-operative massage, 3 times a week, right ankle, per 06/10/15 order Qty: 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 13.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines massage Page(s): 60.

**Decision rationale:** The California MTUS section on massage states: Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Scientific studies show contradictory results. Furthermore, many studies lack long-term follow-up. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. (Hasson, 2004) A very small pilot study showed that massage can be at least as effective as standard medical care in chronic pain syndromes. Relative changes are equal, but tend to last longer and to generalize more into psychologic domains. (Walach 2003) The strongest evidence for benefits of massage is for stress and anxiety reduction, although research for pain control and management of other symptoms, including pain, is promising. The physician should feel comfortable discussing massage therapy with patients and be able to refer patients to a qualified massage therapist as appropriate. (Corbin 2005) Massage is an effective adjunct treatment to relieve acute postoperative pain in patients who had major surgery, according to the results of a randomized controlled trial recently published in the Archives of Surgery. (Mitchinson, 2007) Massage is indicated for the treatment of pain per the MTUS. However the request is for post-operative massage. The documentation indicates the surgery has been denied and therefore post-operative massage would not be necessary. The request is not medically necessary.

