

Case Number:	CM15-0170109		
Date Assigned:	09/10/2015	Date of Injury:	10/02/2009
Decision Date:	10/08/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	08/28/2015

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: Internal 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 34 year old female, who sustained an industrial injury on 10-02-2009. The injured worker was diagnosed as having tibialis tendonitis, edema, nerve entrapment, traumatic arthritis, ankle effusion, and antalgic gait. Treatment to date has included diagnostics, H wave, and medications. On 10-03-2014, the injured worker complains of pain in the medial and lateral ankle, burning pain in feet, gait abnormality and edema, and feeling unstable on feet. Objective findings were documented only as tibialis post tendon tear-neuropathic pain, sinus tarsi, edema, neuropathy, severe pain, and positive magnetic resonance imaging for development of a deep chondral fissure with subchondral remodeling and cystic change. Her work status was not documented. A request for authorization (10-03-2014) included an Unna boot and ace wrap. A rationale for the requested treatment was not documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unna boot: Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (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 Chapter: Immobilization.

Decision rationale: Based on ODG guidelines, immobilization is not recommended as a primary treatment. Early mobilization, functional treatment and partial weight bearing as tolerated appear to be a favorable treatment strategy for acute ankle sprains when compared with immobilization. However, for patients with a clearly unstable joint: immobilization may be necessary for 4 to 6 weeks, with active and/or passive therapy to achieve optimal function. (Kerkhoffs-Cochrane, 2002) (Shrier, 1995) (Colorado, 2001) Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. (Nash, 2004) Functional treatment for severe ruptures of the lateral ankle ligaments leads to better results than cast immobilization for six weeks. (Pijnenburg, 2000) After surgical reconstruction for chronic lateral ankle instability, early functional rehabilitation was shown to be superior to six weeks immobilization regarding time to return to work and sports. (De Vries-Cochrane, 2006) Comparisons of surgically and non-surgically treated Achilles tendon ruptures have demonstrated that those treated with surgery allow earlier motion and tend to show superior results. However, early motion enhances tendon healing with or without surgery and may be the important factor in optimizing outcomes in patients with Achilles tendon rupture. This RCT supports early motion (progressing to full weight bearing at 8 weeks from treatment) as an acceptable form of rehabilitation in both surgically and non-surgically treated patients with comparable functional results and a low re-rupture rate. (Twaddle, 2007) After ankle fracture surgical fixation, commencing exercise in a removable brace or splint significantly improved activity limitation but also led to a higher rate of adverse events. Because of the potential increased risk, the patient's ability to comply with this treatment regimen is essential. (Lin, 2009) According to this systematic review of treatment for ankle sprains, for mild-to-moderate ankle sprains, functional treatment options (which can consist of elastic bandaging, soft casting, taping or orthoses with associated coordination training) were found to be statistically better than immobilization for multiple outcome measures. (Seah, 2011) According to a Cochrane review, after surgical reconstruction, early functional rehabilitation appears to be superior to immobilization in restoring early function. (De Vries, 2011) While a short period of plaster immobilization or similar rigid support can be helpful in the acute phase of the treatment of lateral ankle injury in facilitating a rapid decrease of pain and swelling, functional treatment for 4 to 6 weeks is preferable to immobilization after that short period. (Kerkhoffs, 2012) New guidelines for treating and preventing ankle sprains in athletes call for functional rehabilitation rather than immobilization for grade I and II sprains, and prophylactic ankle supports for athletes with a history of previous ankle sprains. Grade III sprains should be immobilized for at least 10 days with a rigid stirrup brace or below-knee cast and then controlled therapeutic exercise instituted. In this case, the recommendation is for functional treatment for 4-6 weeks after initial short-term immobilization for the acute injury if necessary. This injury dates back to 2009 with recent report of medial and lateral ankle pain in 10/2014. There is no good evidence to suggest that using functional treatment options (such as an Unna Boot) at this time are recommended. Therefore, based on ODG guidelines and the evidence in this case, the request for Unna boot is not medically necessary.

Ace wrap x 1: Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (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 Chapter: Immobilization.

Decision rationale: Not recommended as a primary treatment. Early mobilization, functional treatment and partial weight bearing as tolerated appear to be a favorable treatment strategy for acute ankle sprains when compared with immobilization. However, for patients with a clearly unstable joint: immobilization may be necessary for 4 to 6 weeks, with active and/or passive therapy to achieve optimal function. (Kerkhoffs-Cochrane, 2002) (Shrier, 1995) (Colorado, 2001) Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. (Nash, 2004) Functional treatment for severe ruptures of the lateral ankle ligaments leads to better results than cast immobilization for six weeks. (Pijnenburg, 2000) After surgical reconstruction for chronic lateral ankle instability, early functional rehabilitation was shown to be superior to six weeks immobilization regarding time to return to work and sports. (De Vries-Cochrane, 2006) Comparisons of surgically and non-surgically treated Achilles tendon ruptures have demonstrated that those treated with surgery allow earlier motion and tend to show superior results. However, early motion enhances tendon healing with or without surgery and may be the important factor in optimizing outcomes in patients with Achilles tendon rupture. This RCT supports early motion (progressing to full weight bearing at 8 weeks from treatment) as an acceptable form of rehabilitation in both surgically and non-surgically treated patients with comparable functional results and a low re-rupture rate. (Twaddle, 2007) After ankle fracture surgical fixation, commencing exercise in a removable brace or splint significantly improved activity limitation but also led to a higher rate of adverse events. Because of the potential increased risk, the patient's ability to comply with this treatment regimen is essential. (Lin, 2009) According to this systematic review of treatment for ankle sprains, for mild-to-moderate ankle sprains, functional treatment options (which can consist of elastic bandaging, soft casting, taping or orthoses with associated coordination training) were found to be statistically better than immobilization for multiple outcome measures. (Seah, 2011) According to a Cochrane review, after surgical reconstruction, early functional rehabilitation appears to be superior to immobilization in restoring early function. (de Vries, 2011) While a short period of plaster immobilization or similar rigid support can be helpful in the acute phase of the treatment of lateral ankle injury in facilitating a rapid decrease of pain and swelling, functional treatment for 4 to 6 weeks is preferable to immobilization after that short period. (Kerkhoffs, 2012) New guidelines for treating and preventing ankle sprains in athletes call for functional rehabilitation rather than immobilization for grade I and II sprains, and prophylactic ankle supports for athletes with a history of previous ankle sprains. Grade III sprains should be immobilized for at least 10 days with a rigid stirrup brace or below-knee cast and then controlled therapeutic exercise instituted. In this case, the recommendation is for functional treatment for 4-6 weeks after initial short term immobilization for the acute injury if necessary. This injury dates back to 2009 with recent report of medial and lateral ankle pain in

10/2014. There is no good evidence to suggest that using functional treatment options (such as an Ace wrap) at this time are recommended. Therefore, based on ODG guidelines and the evidence in this case, the request for an Ace wrap is not medically necessary.