

Case Number:	CM15-0073263		
Date Assigned:	04/23/2015	Date of Injury:	06/08/2012
Decision Date:	07/27/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	04/16/2015

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 York

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 51-year-old female, who sustained an industrial injury on June 8, 2012. She reported neck pain, low back pain, left lower extremity pain and status post open reduction internal fixation of a left ankle fracture. The injured worker was diagnosed as having thoracic disc degeneration, thoracic radiculopathy, lumbar disc degeneration, chronic pain, lumbar radiculopathy and thoracic compression fracture. Treatment to date has included radiographic imaging, diagnostic studies, physical therapy, pain injections, medications and work restrictions. Currently, the injured worker complains of neck pain, low back pain and left lower extremity pain with associated radicular symptoms to the upper and lower extremities. The injured worker reported an industrial injury in 2012, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. She reported improvements in pain with physical therapy and steroid injections. Evaluation on November 3, 2014, revealed continued pain as noted. Post-operative physical therapy and equipment were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

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) Knee & 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--Durable Medical Equipment.

Decision rationale: As per ODG, durable medical equipment (DME) is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME), which is defined as equipment that can withstand repeated use, can be rented and used by successive patients, and is primarily and customarily used to serve medical purpose. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Review of the Medical Records of this injured worker does not meet these guidelines. Records also indicate that the request for left ankle surgery has not been certified. Requested Treatment for Shower boot is not medically necessary.

C AM Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Chapter Cam walker.

Decision rationale: The prescription for C AM Walker is evaluated in light Official Disability Guidelines (ODG). As per ODG, it is not recommended in the absence of a clearly unstable joint or a severe ankle sprain. Functional treatment appears to be the favorable strategy for treating acute ankle sprains when compared with immobilization. Partial weight bearing as tolerated is recommended. 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. Review of the Medical Records of this injured worker does not meet these guidelines. Records also indicate that the request for left ankle surgery has not been certified. Requested Treatment for CAM Walker is not medically necessary.

Hot/cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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--Cold/heat packs.

Decision rationale: As per ODG, Ice massage compared to control had a statistically beneficial effect on ROM, function and knee strength. Cold packs decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs did not affect pain significantly compared to control in patients with knee osteoarthritis. ODG states Continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of surgery. For heat therapy, special equipment is not needed. Although the use of equipment is appropriate post-operatively, the injured worker is more than a year status post ORIF of left ankle. Records also indicate that the request for recent left ankle surgery has not been certified. Request does clearly specify which body parts this unit will be used. Based on the currently available information, the medical necessity for Hot/cold therapy unit is not medically necessary. .

Interferential unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

Decision rationale: As per MTUS guidelines Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. The submitted Medical Records of this injured worker neither do clearly specify which body parts this unit will be used, nor does it give any information about parameters for frequency of stimulation, the pulse duration, treatment time, and electrode-placement. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of guidelines, the medical necessity for Interferential Current Stimulation (ICS) unit has not been established. Requested Treatment for Interferential Current Stimulation (ICS) is not medically necessary.

Knee walker: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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: Ankle and Foot Chapters- Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: As per ODG, durable medical equipment (DME) is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME), which is defined as equipment that can withstand repeated use, can be rented and used by successive patients, and is primarily and customarily used to serve medical purpose. Assistive devices for ambulation can reduce pain associated with osteoarthritis. Review of the Medical Records of this injured worker does not have enough information that meets the Official Disability Guidelines (ODG). Therefore, requested treatment Knee walker is not medically necessary and appropriate.

Post operative physical therapy 3 times a week for 4 weeks for the left ankle: 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: MTUS recommends 1) 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. 2) 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. The request is for Post-operative physical therapy visits. Records also indicate that the recent request for left ankle surgery has not been certified, therefore, the request for physical therapy is not medically necessary and appropriate.