

Case Number:	CM14-0101272		
Date Assigned:	07/30/2014	Date of Injury:	06/26/2013
Decision Date:	09/22/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	07/01/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 35-year-old male with date of injury of 06/26/2013. The listed diagnoses per [REDACTED] dated 05/01/2014 are sprain of the hip and thigh; sprain of the knee and leg; closed fracture of the tibia; closed fracture of the tibia shaft, unspecified site of ankle sprain and unspecified site of foot sprain. According to this handwritten progress report, the patient complains of right hip, right knee, right tibia/fibula, right foot/ankle pain, which he rates 2/10. The patient reports mild body pain "without popping and without knocking." The objective findings show lateral/medial knee joint tenderness with increased range of motion moderately. The rest of the report was illegible. The Utilization Review denied the request on 06/12/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Infrared Massage, Myofascial Release, Iontophoresis, Electro-Stimulation-12 visits for hip, thigh, knee, ankle, foot: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: This patient presents with right hip, right knee, right tibia/fibula, and right foot and ankle pain. The treater is requesting an infrared massage, myofascial release, iontophoresis, and electrostimulation x12 visits for the hip, thigh, knee, ankle, and foot. The MTUS guideline under the Chronic Pain section states the following regarding massage therapy: "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." It is unclear from the 124 page medical file, if the patient had prior myofascial release treatments as the treating physician does not provide treatment history. In this case, the requested 12 visits exceed MTUS recommendations. This request is not medically necessary.

Dexamethasone Sodium Phosphate 4mg/ml Injection Qty: 12: 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) Pain injections general: Consistent with the intent of relieving pain, improving function, decreasing medications, and encouraging return to work, repeat pain and other injections not otherwise specified in a particular section in ODG, should at a very minimum relieve pain to the extent of 50% for a sustained period, and clearly result in documented reduction in pain medications, improved function, and/or return to work.

Decision rationale: This patient presents with right hip, right knee, right tibia/fibula, and right foot and ankle pain. The treater is requesting Dexamethasone Sodium Phosphate 4 mg/mL injection, #12. The Utilization Review denied the request stating, "There is no documentation of any arthropathy or joint swelling or any inflammatory type of condition requiring steroid injections on one occasional let alone 12." The MTUS and ACOEM guidelines do not address this request; however, ODG on pain injections states, "Consistent with the intent of relieving pain, improving function, decreasing medications, and encouraging return to work, repeat pain and other injections not otherwise specified in a particular section in ODG, should at a very minimum relieve pain to the extent of 50% for a sustained period, and clearly result in documented reduction in pain medications, improved function, and/or return to work." While ODG supports the use of injections for pain relief, the treating physician does not specify which body part this injection is intended for. Furthermore, the treater is requesting initial 12 injections. ODG requires documentation of pain relief to consider repeat injections. This request is not medically necessary.

EMG of the lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines has the following regarding Electrodiagnostic Studies: See also Nerve

conduction studies (NCS) which are not recommended for low back conditions, and EMGs (Electromyography) which are recommended as an option for low back. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:(1) EDX testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy).(2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable.(3) The number of tests performed should be the minimum needed to establish an accurate diagnosis.(4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed.(5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.(6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. If both tests are done, the reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.(7) If both tests are done, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009) Note: For low back NCS are not recommended and EMGs are recommended in some cases, so generally they would not both be covered in a report for a low back condition.ODG guidelines have the following regarding EMG studies: Recommended as an option (needle, not surface). EMGs (elec.

Decision rationale: This patient presents with right hip, right knee, right tibia/fibula, and right foot and ankle pain. The treater is requesting an EMG of the lower extremities. The ACOEM Guidelines page 303 states that electromyography (EMG) including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG also states that EMG studies are recommended as an option to obtain unequivocal evidence of radiculopathy after one month of conservative therapy but EMGs are not necessary if radiculopathy is already clinically obvious. The records do not show previous EMG reports. The 08/20/2013 report notes that the patient's right hip/thigh reveals normal configuration with no ecchymosis, abrasions, lacerations, sutures or swelling. The right knee has 1+ swelling and some tenderness over the medial and lateral joint lines. Progress reports do not discuss low back pain or sensory deficits that would warrant an EMG. This request is not medically necessary.

MRI of right ankle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 372. Decision based on Non-MTUS Citation Official Disability Guidelines-Foot & Ankle MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC guidelines has the following:(<http://www.odg-twc.com/odgtwc/ankle.htm>) Recommended as indicated below. MRI provides a more definitive visualization of soft tissue structures, including ligaments, tendons, joint capsule, menisci and joint cartilage structures, than x-ray or Computerized Axial Tomography in the evaluation of traumatic or degenerative injuries. (Colorado, 2001) (ACR-ankle, 2002) (ACR-foot, 2002) The majority of patients with heel pain can be successfully treated conservatively, but in cases requiring surgery (eg, plantar fascia rupture in competitive athletes, deeply infiltrating plantar fibromatosis, masses causing tarsal tunnel syndrome), MR imaging is especially useful in planning surgical treatment by showing the exact location and extent of the lesion. (Narvaez, 2000) See also ACR Appropriateness Criteria. Indications for imaging -- MRI (magnetic resonance imaging): Chronic ankle pain, suspected osteochondral injury, plain films normal. Chronic ankle pain, suspected tendinopathy, plain films normal. Chronic ankle pain, pain of uncertain etiology, plain films normal. Chronic foot pain, pain and tenderness over navicular tuberosity unresponsive to conservative therapy, plain radiographs showed accessory navicular. Chronic foot pain, athlete with pain and tenderness over tarsal navicular, plain radiographs are unremarkable. Chronic foot pain, burning pain and paresthesias along the plantar surface of the foot and toes, suspected of having tarsal tunnel syndrome. Chronic foot pain, pain in the 3-4 web space with radiation to the toes, Morton's neuroma is clinically suspected. Chronic foot pain, young athlete presenting with localized pain at the plantar aspect of the heel, plantar fasciitis is suspected clinically.

Decision rationale: This patient presents with right hip, right knee, right tibia/fibula, and right foot and ankle pain. The treater is requesting an MRI of the right ankle. The ACOEM Guidelines pg. 374 on MRI of the foot/ankle states that for patients with continued limitations of activity after 4 weeks of symptoms and unexplained physical findings, imaging may be indicated to clarify the diagnosis and assisting reconditioning. MRIs may be helpful to clarify diagnosis such as osteochondritis dissecans in cases of delayed recovery. ODG further states that MRI provides some more definitive visualization of soft tissue structures including ligaments, tendon, joint capsule, meniscus, and joint cartilage structures than x-ray or computerized axial tomography in the evaluation of traumatic or degenerative injuries. The 08/20/2013 report notes that the patient complains of intermittent right leg, foot and ankle pain described as pins and needles, numb and tingling. Inspection of the right foot and ankle reveals 1+swelling. No atrophy, ecchymosis or abrasion was noted. On 02/21/2014, patient underwent an MRI of the right ankle which showed tenosynovitis in the posterior tibial tendon and flexor hallucis longus and tendinosis in the Achilles tendon. It is unclear why the treater is requesting a repeat MRI. There is no new injury or worsening of symptoms to warrant additional imaging at this time. This request is not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 Page 138.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Functional Capacity Evaluation. ACOEM guidelines has the following regarding functional capacity evaluations: chapter:7(p137,139)"The examiner is responsible for determining whether the impairment results in functional limitations and to inform the examinee and the employer about the examinee's abilities and limitations. The physician should state whether the work restrictions are based on limited capacity, risk of harm, or subjective examinee tolerance for the activity in question. The employer or claim administrator may request functional ability evaluations, also known as functional capacity evaluations to further assess current work capability. These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial. Though functional capacity evaluations are widely used and promoted, it is important for physicians and others to understand the limitations and pitfalls of these evaluations. Functional capacity evaluations may establish physical abilities, and also facilitate the examinee/employer relationship for return to work. However, FCEs can be deliberately simplified evaluations based on multiple assumptions and subjective factors, which are not always apparent to their requesting physician. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities. As with any behavior, an individual's performance on an FCE is probably influenced by multiple nonmedical factors other than physical impairments. For these reasons, it is problematic to rely solely upon the FCE results for determination of current work capability and restrictions. It is the employer's responsibility to identify and determine whether reasonable accommodations are possible to allow the examinee to perform the essential job activities."

Decision rationale: This patient presents with right hip, right knee, right tibia/fibula, and right foot and ankle pain. The treater is requesting a Functional Capacity Evaluation. The ACOEM Guidelines on functional capacity evaluation pgs. 137-139 state that there is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects an what an actual individual can do in a single day at a particular time under controlled circumstances that provide an indication of that individual's abilities. In addition, an individual's performance in an FCE is probably influenced by multiple non-medical factors other than physical impairments. For this reason, it is problematic to rely solely upon the FCE results for determination of current work capabilities and restrictions. The 05/01/2014 report does not provide a rationale behind requesting an FCE. In this case, routine FCEs are not supported by the guidelines unless asked by an administrator/employer or if the information is crucial. This request is not medically necessary.