Case Number:	CM15-0109962		
Date Assigned:	06/17/2015	**Date of Injury:**	11/04/2012
Decision Date:	09/02/2015	**UR Denial Date:**	05/11/2015
Priority:	Standard	**Application Received:**	06/08/2015

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 51 year old female, who sustained an industrial injury on 11/04/2012. She has reported subsequent left foot and ankle pain and was diagnosed with reflex sympathetic dystrophy of the lower limb, neuropathy in other diseases and pain in joint of ankle and foot. Treatment to date has included medication, three lumbar sympathetic blocks, physical therapy and surgery. In a progress note dated 05/04/2015, the injured worker noted that foot pain was reduced by 50% after sympathetic blocks but still had a lot of pain with prolonged standing and walking. Objective findings were notable for antalgic gait, pain with range of motion of the left foot, tenderness to palpation over the heel, midfoot and tarsal tunnel, decreased range of motion of the left ankle, tenderness to touch over the entire ankle and forefoot, sensory changes to cool spray over the posterior tibial nerve distribution, tenderness over the heel and plantar fascia and equivocal Tinel's over the tarsal tunnel. A request for authorization of referral to a podiatrist for the left foot for peripheral nerve diagnostic blocks, referral to a podiatrist for a second opinion regarding pain, six sessions of physical therapy to the left foot and radiofrequency lesioning procedure to the left foot (post physical therapy) was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to a podiatrist for the left foot for peripheral nerve diagnostic blocks: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127 and Aetna Clinical Policy 0863, regarding Peripheral Nerve Blocks.

Decision rationale: Based on the 05/04/15 progress report provided by treating physician, the patient presents with swelling and pain to left foot rated 6/10, with pain and burning feeling to ankle and posterior achilles area. The patient is status post excision of infracalcaneal neuroma, excision of heel spur with plantar fasciotomy, remodeling of the medial aspect of the anatomic navicular on 07/19/13. The request is for referral to a podiatrist for the left foot for peripheral nerve diagnostic blocks. Patient's diagnosis per Request for Authorization form dated 05/04/15 includes reflex sympathetic dystrophy of lower limb, neuropathy in other diseases, pain in joint of ankle and foot. The patient has antalgic gait assisted by a cane. Physical examination to the left foot on 05/04/15 revealed well-healed scars on the medial side, and tenderness to palpation noted over heel, midfoot and tarsal tunnel. Range of motion decreased. Dorsiflexion 15 degrees and plantar flexion 25 degrees. The patient had "lumbar sympathetic blocks on 2/4, 2/27, 3/4 with at least 50% pain relief." Patient's medications include Cymbalta, Naproxen, Prilosec, Ultracet, Neurontin and Lunesta. The patient is not working, per 05/04/15 report. Treatment reports provided from 11/25/14 - 05/04/15. ACOEM Chapter 14, page 371 states: "Invasive techniques (e.g., needle acupuncture and injection procedures) have no proven value, with the exception of corticosteroid injection into the affected web space in patients with Morton's neuroma or into the affected area in patients with plantar fasciitis or heel spur if four to six weeks of conservative therapy is ineffective." The ODG-TWC, Ankle & Foot (Acute & Chronic) Chapter under Injections (corticosteroid) states: "Not recommended for tendonitis or Morton's Neuroma, and not recommend intra-articular corticosteroids. Heel pain (plantar fasciitis): Under study. There is no evidence for the effectiveness of injected corticosteroid therapy for reducing plantar heel pain. (Crawford, 2000) Tendon (Achilles tendonitis): Not Cortisone injections in the area of the Achilles tendon are controversial because cortisone injected around the tendon is harmful and can lead to Achilles tendon ruptures...." Aetna Clinical Policy 0863, regarding Peripheral Nerve Blocks states: "Aetna considers the use of peripheral nerve blocks (continuous or single-injection) medically necessary for the treatment of (i) acute pain, and (ii) for chronic pain only as part of an active component of a comprehensive pain management program. Peripheral nerve blocks as sole treatment for chronic pain is considered experimental and investigational...there is currently insufficient evidence to support the use of peripheral nerve blocks in the treatment of peripheral neuropathy or other indications." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7 page 127 has the following: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." ACOEM guidelines further states, referral to a specialist is recommended to aid in complex issues. Per 03/16/15 report, treater states "I would like [the patient] to be seen by a Foot and Ankle specialist who specializes in peripheral nerve issues and possible neurolytic/Botox injections which will reduce signal firing 'propagation' of the pain afferent signal and reduce the release of pro inflammator medicators... referral to [redacted] for some peripheral nerve

diagnostic blocks and a consultation for a second opinion regarding her pain... [the patient] has peripheral pain, she has CRPS and she has sympathetic pain." Treatment to date has included surgery, 4-5 injections to left heel, post-op physical therapy and medications, and the patient continues with pain. It would appear that the current treater feels uncomfortable with the patient's medical issues and has requested second opinion consultation. Given the patient's postoperative status, continued pain symptoms and diagnosis, this request appears reasonable. The patient's foot symptoms could benefit from additional specialist treatment and consultations, which are supported by guidelines at the treater's discretion. Therefore, the request IS medically necessary.

Referral to a podiatrist for a second opinion regarding pain: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127.

Decision rationale: Based on the 05/04/15 progress report provided by treating physician, the patient presents with swelling and pain to left foot rated 6/10, with pain and burning feeling to ankle and posterior achilles area. The patient is status post excision of infracalcaneal neuroma, excision of heel spur with plantar fasciotomy, remodeling of the medial aspect of the anatomic navicular on 07/19/13. The request is for referral to a podiatrist for a second opinion regarding pain. Patient's diagnosis per Request for Authorization form dated 05/04/15 includes reflex sympathetic dystrophy of lower limb, neuropathy in other diseases, pain in joint of ankle and foot. The patient has antalgic gait assisted by a cane. Physical examination to the left foot on 05/04/15 revealed well-healed scars on the medial side, and tenderness to palpation noted over heel, midfoot and tarsal tunnel. Range of motion decreased. Dorsiflexion 15 degrees and plantar flexion 25 degrees. The patient had "lumbar sympathetic blocks on 2/4, 2/27, 3/4 with at least 50% pain relief." Patient's medications include Cymbalta, Naproxen, Prilosec, Ultracet, Neurontin and Lunesta. The patient is not working, per 05/04/15 report. Treatment reports provided from 11/25/14 - 05/04/15. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7 page 127 has the following: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." ACOEM guidelines further states, referral to a specialist is recommended to aid in complex issues. Per 03/16/15 report, treater states "I would like [the patient] to be seen by a Foot and Ankle specialist who specializes in peripheral nerve issues and possible neurolytic/Botox injections which will reduce signal firing 'propagation' of the pain afferent signal and reduce the release of pro inflammatory medicators... referral to [redacted] for some peripheral nerve diagnostic blocks and a consultation for a second opinion regarding her pain... [the patient] has peripheral pain, she has CRPS and she has sympathetic pain." Treatment to date has included surgery, 4-5 injections to left heel, post-op physical therapy and medications, and the patient continues with pain. It would appear that the current treater feels uncomfortable with the patient's medical issues and has requested second opinion pain consultation. Given the patient's continued pain symptoms and diagnosis, this request appears reasonable. The patient's foot symptoms could benefit from

additional specialist treatment and consultations, which are supported by guidelines at the treater's discretion. Therefore, the request IS medically necessary.

Physical Therapy to the left foot, six sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: Based on the 05/04/15 progress report provided by treating physician, the patient presents with swelling and pain to left foot rated 6/10, with pain and burning feeling to ankle and posterior achilles area. The patient is status post excision of infracalcaneal neuroma, excision of heel spur with plantar fasciotomy, remodeling of the medial aspect of the anatomic navicular on 07/19/13. The request is for physical therapy to the left foot, six sessions. Patient's diagnosis per Request for Authorization form dated 05/04/15 includes reflex sympathetic dystrophy of lower limb, neuropathy in other diseases, pain in joint of ankle and foot. The patient has antalgic gait assisted by a cane. Physical examination to the left foot on 05/04/15 revealed well-healed scars on the medial side, and tenderness to palpation noted over heel, midfoot and tarsal tunnel. Range of motion decreased. Dorsiflexion 15 degrees and plantar flexion 25 degrees. The patient had "lumbar sympathetic blocks on 2/4, 2/27, 3/4 with at least 50% pain relief." Treatment to date has included surgery, 4-5 injections to left heel, post-op physical therapy and medications. Patient's medications include Cymbalta, Naproxen, Prilosec, Ultracet, Neurontin and Lunesta. The patient is not working, per 05/04/15 report. Treatment reports provided from 11/25/14 - 05/04/15. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks." Treater states in 03/16/15 report "the last series of PT [the patient] had was on her left foot after the surgery." Treater states the patient "has allodynia and dysesthesia to touch and temperature...The question is whether or not this is an SMP or SIP (sympathetically mediated pain Vs. Sympathetically independent pain) Treatment for this is complex and needs to be done in a multidisciplinary fashion." In this case, the patient is postoperative (though no longer within treatment period) and has a diagnosis of CRPS. MTUS allows up to "24 visits over 16 weeks." Per 01/19/15 report, treater states the patient attended 12 sessions of physical therapy at [redacted] This request for 6 additional sessions of physical therapy appears reasonable and in accordance with the guidelines. Therefore, the request IS medically necessary.

Radiofrequency lesioning procedure to the left foot (post physical therapy): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371; 376. Decision based on Non-MTUS Citation Official Disability Guidelines, Ankle and Foot Chapter, Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pulsed radiofrequency treatment (PRF) Page(s): 102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot (Acute & Chronic) Chapter under Radiofrequency treatment : See Coblation therapy.

Decision rationale: Based on the 05/04/15 progress report provided by treating physician, the patient presents with swelling and pain to left foot rated 6/10, with pain and burning feeling to ankle and posterior achilles area. The patient is status post excision of infracalcaneal neuroma, excision of heel spur with plantar fasciotomy, remodeling of the medial aspect of the anatomic navicular on 07/19/13. The request is for radiofrequency lesioning procedure to the left foot (post physical therapy). Patient's diagnosis per Request for Authorization form dated 03/16/15 includes reflex sympathetic dystrophy of lower limb, neuropathy in other diseases, pain in joint of ankle and foot. The patient has antalgic gait assisted by a cane. Physical examination to the left foot on 05/04/15 revealed well-healed scars on the medial side, and tenderness to palpation noted over heel, midfoot and tarsal tunnel. Range of motion decreased. Dorsiflexion 15 degrees and plantar flexion 25 degrees. The patient had "lumbar sympathetic blocks on 2/4, 2/27, 3/4 with at least 50% pain relief." Treatment to date has included surgery, 4-5 injections to left heel, post-op physical therapy and medications. Patient's medications include Cymbalta, Naproxen, Prilosec, Ultracet, Neurontin and Lunesta. The patient is not working, per 05/04/15 report. Treatment reports provided from 11/25/14 - 05/04/15. MTUS page 102 regarding Pulsed radiofrequency treatment (PRF) states: "Not recommended. Pulsed radiofrequency treatment (PRF) has been investigated as a potentially less harmful alternative to radiofrequency (RF) thermal neurolytic destruction (thermocoagulation) in the management of certain chronic pain syndromes such as facet joint pain and trigeminal neuralgia. Pulsed radiofrequency treatment is considered investigational/not medically necessary for the treatment of chronic pain syndromes. (BlueCross, 2005) A decrease in pain was observed in patients with herniated disc and spinal stenosis, but not in those with failed back surgery syndrome. However, this option does not appear to be an ideal modality of treatment for lumbar radicular pain because neurodestructive methods for the treatment of neuropathic pain are in principle generally considered inappropriate. (Abejn, 2007)" ODG-TWC, Ankle & Foot (Acute & Chronic) Chapter under Radiofrequency treatment states: "See Coblation therapy: Under study. Coblation devices direct radiofrequency energy, rupturing target tissue cells and disintegrating molecules with minimal heat production. Coblation technology can be delivered by a variety of wands, hand pieces and stylette tips used at different anatomic sites. Coblation-based wands such as the Topaz Microdebrider [redacted], [redacted]) are used for debridement, decompression, and removal of soft tissue during minimally invasive arthoscopic procedures involving tendons in the ankle and foot. Currently, there are no randomized controlled trials in the medical literature demonstrating the efficacy of Coblation technology and related devices for treatment of joint or musculoskeletal soft tissue conditions. Further prospective, randomized studies with large sample sizes reporting long-term outcomes are needed to demonstrate the safety and efficacy of this approach compared to established methods of management of musculoskeletal conditions. Topaz coblation or Topaz radiofrequency is often used by podiatrists as a treatment for recalcitrant tendon problems of the foot such as the achilles or peroneal tendinosis or for plantar fasciitis. (Sherk, 2002)" Treater states in 03/16/15 report "the last series of PT [the patient] had was on her left foot after the surgery." Treater states the patient "has

allodynia and dysesthesia to touch and temperature...The question is whether or not this is an SMP or SIP (sympathetically mediated pain Vs. Sympathetically independent pain) Treatment for this is complex and needs to be done in a multidisciplinary fashion. .. I want to request a Pulsed Radiofrequency lesioning of the sympathetic chain. This will cause deafferentiation of the C and ADelta fibers and reduce [the patient's] pain hopefully for 6-8 months at a time." MTUS states that "Pulsed radiofrequency treatment is considered investigational/not medically necessary for the treatment of chronic pain syndromes." While ODG states "used by podiatrists as a treatment for recalcitrant tendon problems of the foot such as the achilles or peroneal tendinosis or for plantar fasciitis," this procedure "is under study." This request cannot be warranted without support from guidelines. Therefore, the request IS NOT medically necessary.