

Case Number:	CM15-0197049		
Date Assigned:	10/12/2015	Date of Injury:	12/22/2014
Decision Date:	11/30/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/06/2015

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, Hawaii
 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 26 year old male, who sustained an industrial-work injury on 12-22-14. He reported initial complaints of left lower extremity pain. The injured worker was diagnosed as having status open reduction and internal fixation (ORIF) of tibial fibular fracture, deep peroneal palsy causing dorsiflexion weakness of the left great toe and neuritic pain, post traumatic arthrofibrosis, left ankle, causing lateral impingement lesion, and retained screw, left tibia, causing moderate skin irritation. Treatment to date has included medication, surgery (locked intermedullary rodding of left tibia shaft fracture). Currently, the injured worker complains of increased left leg pain, foot, and ankle with rating of 3-4 out of 10 with rest and 8-9 out of 10 at worst with weight bearing activities. There was also tingling and numbness that radiated from the proximal fibula to the left foot. Medications included Tramadol, Mobic, and Gabapentin. Per the primary physician's progress report (PR-2) on 9-8-15, exam notes moderate to severe tenderness to the common peroneal nerve of his left leg with a positive Tinel's that radiates to the left foot. There is a very prominent screw which appears to have backed out to the lower leg and ankle region which has moderate tenderness, moderate tenderness to the lateral gutter and medial shoulder of the left ankle with 1+ edema, range of motion is equal, and no joint instability. Vascular exam is normal and neurological exam notes decreased sensation in a peroneal nerve distribution of the left leg. The Request for Authorization requested service to include 12 sessions of physiotherapy and 3 Cortisone injections, left peroneal nerve and left ankle. The Utilization Review on 9-22-15 denied the request for 12 sessions of physiotherapy and 3 Cortisone injections, left peroneal nerve and left ankle, per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Medical Treatment Guidelines 2009; Ankle and Foot Complaints 2004.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 sessions of physiotherapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The patient presents with increased left leg pain with tingling and numbness that radiate from the proximal fibula to the left foot with weakness in his toes and left foot. The current request is for 12 sessions of physiotherapy. The patient completed 8 postoperative sessions of physical therapy from 4/23/15 to 5/19/15. Patient is status post locked intramedullary rodding of left tibia shaft fracture on 12/22/14. The consulting physician states on 8/17/15 (213B) the patient "sustained severe crush injury to his left foot, ankle and lower leg which has cause nerve damage to the left deep peroneal nerve (fibular nerve) which is causing pain to his left leg, foot and ankle as well as weakness of his dorsiflexion of his left great toe. He also is suffering from scar tissue in his ankle, which is restricting motion and causing pain and also a screw that has backed out, causing significant skin irritation. At this point, treatment plan is aimed at reducing the pain from the peroneal neuropathy or palsy. To this end, I would like to request 12 physiotherapy/rehab visits aimed at the peroneal nerve as well as cortisone injections into the peroneal nerve to see if we can reduce the pain and restore some function." MTUS guidelines indicate that Physical Therapy is recommended: Physical Medicine guidelines state "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." For myalgia and neuritis type conditions, MTUS Guidelines recommend 8-10 sessions of physical therapy. Although PT may be warranted in this case, the current request for 12 sessions exceeds what MTUS allows for this type of condition. The current request is not medically necessary.

3 Cortisone injections, left peroneal nerve and left ankle: Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ankle & Foot (Acute & Chronic) - Injections (corticosteroid).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Online, Knee and Leg Chapter, Corticosteroid injections.

Decision rationale: The patient presents with increased left leg pain with tingling and numbness that radiate from the proximal fibula to the left foot with weakness in his toes and left foot. The current request is for 3 cortisone injections, left peroneal nerve and left ankle. The consulting physician states on 8/17/15 (213B) the patient "sustained severe crush injury to his left foot, ankle and lower leg which has cause nerve damage to the left deep peroneal nerve (fibular nerve) which is causing pain to his left leg, foot and ankle as well as weakness of his dorsiflexion of his left great toe. He also is suffering from scar tissue in his ankle, which is restricting motion and causing pain and also a screw that has backed out, causing significant skin irritation. At this point, treatment plan is aimed at reducing the pain from the peroneal neuropathy or palsy. To

this end, I would like to request 12 physiotherapy/rehab visits aimed at the peroneal nerve as well as cortisone injections into the peroneal nerve to see if we can reduce the pain and restore some function." MTUS Guidelines do not address cortisone injections at the peroneal nerve. ODG states, "Recommended for short-term use only." ODG lists with the following criteria for injection: "Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease; Intended for short-term control of symptoms to resume conservative medical management or delay TKA; Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three." Although a cortisone injection may be warranted in this case, the request for 3 exceeds ODG's recommendation of starting with one. The current request is not medically necessary.