

<b>Case Number:</b>	CM15-0125950		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	07/23/2014
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 43-year-old female with an industrial injury dated 06/23/2014. The injury is documented as occurring while walking upstairs, took a step and her right big toe bent backwards. Her diagnoses included right foot sprain/strain, aggravation of hallux limitus condition and right first MPT joint capsulitis. Prior treatment included x-rays (negative for fracture) and anti-inflammatory medication. Comorbid diagnoses included hypertension and hypothyroid. She presents on 05/14/2014 with complaints of pain in her right great toe, which is made worse with walking and standing. Physical exam revealed palpable pulses with capillary refill time brisk and immediate. Superficial and deep sensations are intact. Deep tendon reflexes were normal. There was mild pain in the big toe without crepitation on range of motion. The provider documents X-rays showed no acute fractures. She was able to resume her usual customary work. The treatment plan included custom foot orthotics, physical therapy and right foot injections. The requested treatments included custom molded orthotics, physical therapy times 12 and Synvisc/Hyalgan/Cortisone injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Synvisc/Hyalgan/Cortisone injections:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-352. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Hyaluronic acid injections.

**Decision rationale:** Synvisc is a high molecular weight hyaluronan. MTUS is silent regarding the use of synvisc injections. ODG states "Not recommended, based on recent research in the ankle, plus several recent quality studies in the knee showing that the magnitude of improvement appears modest at best was formerly under study as an option for ankle osteoarthritis. Hyaluronic acids are naturally occurring substances in the body's connective tissues that cushion and lubricate the joints. Intra-articular injection of hyaluronic acid may decrease symptoms of osteoarthritis of the knee, and possibly the ankle. This double blind, randomized, controlled study examined the safety and efficacy of intraarticular sodium hyaluronate (Hyalgan) in the treatment of pain associated with ankle osteoarthritis (OA), and concluded that this may be a safe and effective option for pain associated with ankle OA, although larger studies are needed. (Cohen, 2008) This clinical trial suggested that viscosupplementation combined with arthroscopy may be more beneficial than arthroscopy alone. (Carpenter, 2008) The goal of this study was to determine whether hyaluronic acid (HA) or exercise therapy can improve functional parameters in patients with osteoarthritis (OA) of the ankle, and both HA injections and exercise therapy provided similar functional improvement. However, larger trials with longer follow-up are necessary for more definite conclusions. (Karatosun, 2008) According to this systematic review of treatment for ankle sprains, therapeutic hyaluronic acid injections in the ankle may have a role in expediting return to sport after ankle sprain, but evidence is limited. (Seah, 2011) See the Knee Chapter for more information. Recent research: While intra-articular injections of hyaluronic acid are potentially useful to treat ankle osteoarthritis, their effectiveness has not been proven. This RCT comparing hyaluronic acid with placebo for ankle osteoarthritis concluded that hyaluronic acid is not superior to saline solution injection. (DeGroot, 2012) Hyaluronic acid or Hylan for the Ankle is Not Recommended by ODG. Patient selection criteria for ankle hyaluronic acid injections if provider & payor agree to perform anyway: A series of three to five intra-articular injections of Hyaluronic acid (or just three injections of Hylan) in the target ankle with an interval of one week between injections. Indicated for patients who: Experience significantly symptomatic osteoarthritis but have not responded adequately to standard non-pharmacologic and pharmacologic treatments or are intolerant of these therapies (e.g., gastrointestinal problems related to anti-inflammatory medications). Are not candidates for total ankle replacement or who have failed previous ankle surgery for their arthritis, such as arthroscopic debridement. Repeat series of injections: If relief for 6-9 months and symptoms recur, may be reasonable to do another series. Recommend no more than 3 series of injections over a 5-year period, because effectiveness may decline, this is not a cure for arthritis, but only provides comfort and functional improvement."Guidelines recommend against the use of these types of injections. The treating physician has not provided rationale to go against guidelines. As such, the request for Synvisc/Hyalgan/Cortisone injections is not medically necessary.

**Physical therapy x 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 329-360, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 24-25. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Foot & Ankle (Acute & Chronic), Physical Medicine, Physical Therapy.

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine". Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG reports limited positive evidence to support physical therapy for knee complaints. ODG specifies, "Recommended. Exercise program goals should include strength, flexibility, endurance, coordination, and education. Patients can be advised to do early passive range-of-motion exercises at home by a physical therapist. See also specific physical therapy modalities by name. (Colorado, 2001) (Aldridge, 2004) 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 Achilles tendon ruptures. (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 a Cochrane review, neuromuscular training is effective in treating chronic ankle instability. (De Vries, 2011) Active Treatment versus Passive Modalities: In general, the use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530). See the Back Chapter for references". Additionally, ODG quantifies the number of sessions for Ankle/foot Sprain (ICD9 845): Medical treatment: 9 visits over 8 weeks. Post-surgical treatment: 34 visits over 16 weeks. MTUS guidelines further state, "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section." The request for 12 sessions is in excess of the clinical trial guidelines. Additionally, the medical documents do not note "exceptional factors" that would allow for treatment duration in excess of the guidelines. As such, the request for Physical therapy x 12 is not medically necessary.

**Custom molded orthotics:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 365-370. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot (Acute & Chronic), Orthotic devices.

**Decision rationale:** ODG states "Recommended as an option for plantar fasciitis, but not for Achilles tendonitis". ACOEM recommends inserts for plantar fasciitis. ODG states "Recommended for plantar fasciitis and for foot pain in rheumatoid arthritis". MTUS is silent regarding shoe inserts. However, there is no documentation as to why pre-fabricated shoe inserts would not suffice. As such, the request for Custom molded orthotics is not medically necessary.