

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/9/2013



Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/21/2013
Date of Injury:	10/25/2011
IMR Application Received:	8/28/2013
MAXIMUS Case Number:	CM13-0017564

- 1) MAXIMUS Federal Services, Inc. has determined the request for **weekly nerve block great toe/foot (left) is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **additional three month wheelchair rental is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/28/2013 disputing the Utilization Review Denial dated 8/21/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **weekly nerve block great toe/foot (left)** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **additional three month wheelchair rental** is not **medically necessary and appropriate**.

### Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 treatments and/or services at issue.

### Expert Reviewer Case Summary:

This patient's date of injury is 10/25/2011. The date of the initial utilization review decision is 08/21/2013. The patient's primary treating diagnosis is a plantar nerve lesion. Instead it was a crush injury of the left forefoot with a history of a medial dorsal cutaneous neurectomy.

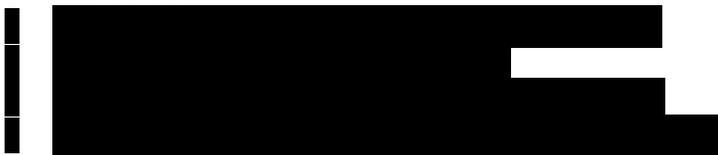
A prior utilization review recommended an additional 3-month wheelchair rental is medically necessary. That review also recommended modifying a request for a weekly nerve block x4 weeks. That review noted that as of 08/07/2013 a progress note indicated that ketamine treatment was helping with foot pain and that the patient wished to have another injection since her pain was continual and the patient had pain with range of motion with posttraumatic complex regional pain syndrome of the foot. That review noted that the patient's treatment in the past had included neurectomy surgery as well as an H-wave unit and also nerve blocks weekly between 06/07/2013 and 07/01/2013 and also on 08/07/2013.

On 08/23/2013, podiatrist [REDACTED] saw the patient in followup and noted the patient had continued pain in the left foot, that the patient requested a local anesthetic injection. [REDACTED] noted that the left forefoot was the area of maximum tenderness and that the patient had an area of allodynia from the ankle to the first metatarsophalangeal joint with hypersensitivity at the proximal junction. [REDACTED] diagnosed the patient with a history of a crush injury and complex regional pain syndrome of the left foot. [REDACTED] requested weekly nerve blocks over 4 weeks and injected the left dorsal forefoot with Marcaine in the form of a field block and recommended the patient return in 1 week for another block.

On 08/21/2013, [REDACTED] saw the patient in followup for examination of the leg and foot. The patient noted physical therapy had been helpful and that she was doing her best to do exercises. On exam, the patient was walking with a mild limp and had diminished range of motion in the left ankle. [REDACTED] felt the patient was improving with ambulation and planned followup in a month.

**Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:



**1) Regarding the request for weekly nerve block great toe/foot (left) :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Colorado Division of Workers' Compensation, Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy (2011) p.107, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Complex Regional Pain Syndrome (CRPS)/Treatment, pg. 40 which is a part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines section on complex regional pain syndrome/treatment states, "Recommend the hierarchy of options as indicated below. The goal is to improve function...Early stages: Build a therapeutic alliance...Next steps: Increase flexibility...Continued steps: Continue active range of motion, stress loading, scrubbing techniques, isotonic strengthening, general aerobic conditioning...Final steps: Normalization of use, assessment of ergonomics, posture and modifications at home and work." A review of the records indicates, that this case appears to emphasize predominantly passive or invasive treatment for complex regional pain syndrome but does not appear to emphasize when to integrate this treatment with active functionally oriented rehabilitation. At this time, the medical records and the guidelines do not support a probable indication of a benefit of weekly nerve blocks for this employee's diagnosis, particularly without specific coordination with active functional restoration. **The request for weekly nerve block great toe/foot (left) is not medically necessary and appropriate.**

## 2) Regarding the request for additional three month wheelchair rental :

### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) Foot and Ankle Chapter, which is not a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Knee, , Wheelchair.

### Rationale for the Decision:

The Official Disability Guidelines/Knee/Wheelchair states, "Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence." A review of the medical records indicates, that this employee had an independent though antalgic gait during the time period under review. The medical records do not establish the necessity of a wheelchair. Moreover, use of a wheelchair would not be consistent with overall guidelines in the California Medical Treatment Utilization Schedule to emphasize active functional restoration. Overall, the necessity of or benefit of an additional 3-month wheelchair rental is not apparent for an employee who had documented substantial gait abilities during the period under review. At minimum, the medical records should document a plan to transition the patient from a wheelchair to gait, which is not present in the medical records at this time. Overall, the medical records do not establish the necessity of an additional wheelchair rental for the time period which had been under review. **The request for additional three month wheelchair rental is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

[Redacted Signature]

Medical Director

cc:

[Redacted Recipients]

/cmol

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.