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Notice of Independent Review Decision

August 12, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Independent pool program, warm pool/health club membership (CPT S9970)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Diagnostics (02/22/11 - 05/27/13)
- Office visits (02/23/11 - 04/16/13)
- Reviews (05/07/12 - 03/21/13)
- Utilization review (03/25/13)
- Procedures (05/16/13)

TDI

- Utilization reviews (07/05/13, 07/17/13)
- Reviews (03/21/13)
- Diagnostic (04/02/13)
- Office visits (04/10/13)
- Procedure (05/16/13)
- Utilization reviews (07/05/13, 07/17/13)

mail

- Diagnostics (02/22/11 – 03/27/13)
- Office visits (03/01/11 – 04/10/13)
- Letters (01/11/12 – 04/15/13)
- Reviews (05/07/12 – 03/21/13)
- Utilization review (02/17/13 – 03/25/13)
- TDI (03/07/13– 07/24/13)
- Surgery (05/16/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was walking along a stairway on xx/xx/xx. She slipped and fell onto her left side. She fell down about three to four steps and sustained injuries to her feet, bilateral hips, left shoulder, neck and lower back.

On xx/xx/xx, the patient underwent computerized tomography (CT) scan of the left foot without contrast to evaluate calcaneus fracture. The study showed comminuted minimally displaced fractures of the calcaneus with no evidence of intra-articular involvement of the posterior facet of the subtalar joint. There was a vertical non-displaced fracture through the anterior calcaneus involving the sustentaculum tali and middle facet of subtalar joint. X-rays of the left foot showed possible comminuted calcaneal fracture with flattening of Bohler's angle. X-rays of the left ankle showed no evidence of acute bony injury in the left ankle.

On February 23, 2011, evaluated the patient for left calcaneal fracture. noted that the patient was seen in emergency room, where an extra-articular fracture of the calcaneus was diagnosed. Both x-rays and computerized tomography (CT) scan were performed. placed the patient in a compressive wrap. The patient had pain and swelling in her left foot and ankle. She stated that the pain was sharp, stabbing, burning, throbbing and constant in nature. She had associated swelling and ecchymosis. Her pain level was 7 to 8/10. The problems listed were displacement of cervical intervertebral disc without myelopathy and displacement of thoracic and lumbar intervertebral disc without myelopathy (onset December 6, 2006). Examination of the left lower extremity showed a large amount of ecchymosis, mainly over the lateral aspect of her left foot and also over the arch of the left foot. Most of the swelling was about the lateral aspect of her left foot and ankle. reviewed the x-rays from emergency room (ER) which showed a fracture of the calcaneus beginning posterior to the posterior facet and extending into the neck of the calcaneus. CT scan showed a fracture line going into the middle facet of the subtalar joint, but no displacement of the fracture. assessed nondisplaced left calcaneal fracture mainly extra-articular and nondisplaced fracture into the middle facet subtalar joint. He opined that there was no need for surgical intervention. The patient was placed in a dressing. recommended non-operative treatment, rest, ice, compression and elevation (RICE), and doing leg lifts, knee range of motion (ROM) and flexion-extension exercise of her toes to diminish her chances of deep vein thrombosis. When her pain and swelling would diminish, she would be placed in a compressive stocking, a fracture boot and

motion exercises. The patient was not allowed to weightbear until the fracture was healed.

On March 1, 2011, evaluated the patient for multiple complaints involving the neck, left shoulder, lower back, numbness to the anterior aspect of the right hip and thigh, low back pain, right hip, left hip and pelvic pain, right foot pain and left hip and left lower extremity pain. The patient was using a wheelchair and had a fiberglass cast to the left leg and foot, which extended from just below the knee down to her toes. The patient was unable to stand or sit upright without increasing the pain to the left foot. The right anterior thigh felt numb since the injury. The patient had prior C5-C6 and C6-C7 discectomy and fusion with titanium plate and she had problem with her low back disc at the L4-L5 level. diagnosed left calcaneal fracture, left foot injury; right foot pain, soft tissue injury, mild in nature without any evidence for fracture or dislocation on clinical exam; bilateral hip pain and pelvic pain consequent to contusion superimposed on pre-existing left trochanteric bursitis; numbness in the right L2 dermatome, rule out disc compression or compressive radiculopathy in the lumbar spine; lower back pain secondary to contusion, rule out disc rupture, herniation with pre-existing disc abnormality at L4-L5; cervical pain with restricted ROM status post previous fusion; left shoulder pain secondary to contusion involving the scapula and anterior glenohumeral joint and sprain/strain with AC joint strain. continued Vicodin as prescribed in the emergency room (ER), added Soma and ordered magnetic resonance imaging (MRI) of the cervical spine and lumbar spine and x-rays of the pelvis, left shoulder and scapula.

On March 3, 2011, MRI of the lumbar spine showed: (1) Spondylotic degenerative changes. (2) Small disc extrusion at the L3-L4 level effacing the right ventral aspect of the thecal sac/lateral recess possibly creating mild mass effects upon the descending right-sided nerve roots including the L4 nerve root distribution. (3) Small outer annular posterior tear at L4-L5 level without protrusion. (4) Mild canal narrowing at the L3-L4 level secondary to a combination of spondylotic degenerative changes, extrusion, facet hypertrophy and ligamentum flavum thickening.

On March 3, 2011, MRI of the cervical spine showed: (1) Stable exam from prior. (2) Stable anterior fusion and discectomy from C5 through C7. (3) Stable mild canal narrowing with effacement of ventral aspect of the thecal sac at the C4-C5 level which demonstrated a change from prior. The cord maintained normal signal and there was preservation of cerebrospinal fluid (CSF) posteriorly without generalized pronounced canal narrowing. (4) Stable neural foraminal narrowing predominantly seen on the right at the C3-C4 level.

On March 11, 2011, reviewed the MRI findings and diagnosed closed fracture of calcaneus and displacement of thoracic or lumbar intervertebral disc without myelopathy. continued cast and medications for pain and recommended consultation.

On March 14, 2011, noted that there was a new disc herniation at L3-L4 producing right L3-L4 radiculopathy. placed the patient into a lumbar corset support during sitting and recommended physical therapy (PT) and epidural steroid injection (ESI) for continued numbness into the right thigh.

On April 4, 2011, reviewed the diagnostic studies and diagnosed non-displaced left intra-articular calcaneus fracture. referred the patient for definitive evaluation. He recommended another CT scan to assess displacement.

On April 13, 2011, evaluated the patient for multiple injuries status post fall. The patient had seen the previous week and had placed her in an outpatient boot. The patient was having some issues with the boot being too large. She was still unable to get a new walker and was going to ask office about that. The left neck pain, left scapular pain and lower back pain seemed to be improved. She continued to have pain on the lateral hip, but that was not significant. diagnosed left calcaneus fracture, cervical strain with radiculopathy, lumbar strain and left hip contusion. He continued Vicodin, Soma and PT and referred the patient for a neurosurgery consultation. He gave a prescription for a walker.

In May and June, recommended holding off regular therapy for neck and back and continuing Vicodin and Soma and pool therapy.

On August 3, 2011, felt that the patient needed repeat imaging of her left calcaneus and ankle. The patient also needed more PT to increase strength of ankle and foot. MRI of the knee had been ordered two days ago. continued modified duty and recommended electromyography/nerve conduction velocity (EMG/NCV) of the left leg to rule out radiculopathy from lumbar strength.

On August 24, 2011, noted that the patient was to follow-up to discuss the MRI findings of the anterior talofibular ligament disruption. recommended keeping PT on hold until decides on treatment. He recommended continuing medications and modified duty.

On September 7, 2011, reviewed the MRI findings that showed a healed calcaneus. He felt that most of the patient's symptoms were due to ligament tear and the patient could improve with further treatment. He continued medications and modified duty and recommended a second opinion.

On September 28, 2011, evaluated the patient for left ankle and foot pain that was aching, severe, constant and worsening. Previously the patient underwent x-rays that confirmed a nondisplaced comminuted calcaneus fracture. Magnetic resonance imaging (MRI) performed on August 11, 2011, showed that the anterior talofibular ligament (ATFL) was chronically disrupted mild marrow edema in the calcaneus. Computerized tomography (CT) scan dated xx/xx/xx, confirmed a minimally displaced comminuted calcaneus fracture. Recently performed electromyography (EMG) showed sensory changes but no motor changes. The patient had not returned to work since her injury. She was seen who placed her in three separate casts, the conservative treatment for the calcaneus apparently

producing union of the calcaneus. Unfortunately, the patient continued to have severe pain with activity with weightbearing. She was unable to tolerate standing on bare feet. She had some decreased sensation at the anterior lateral distal leg. She had pain over the Achilles, the lateral ankle including the peroneal tendons and ATFL. She also had pain across her plantar foot. Medical history was positive for osteoporosis. The patient had a limping gait and she ambulated with a walker. Examination of the left foot/ankle showed tenderness of the lateral side, the gutter ankle, the calcaneal tuberosity and the Achilles tendon insertion. There was tenderness of the Achilles tendon, the sinus tarsi and the peroneal retinaculum. Muscle strength on the left side was 3/5 for peroneus brevis and longus, extensor digitorum longus and brevis at 4/5, extensor hallucis longus (EHL) 4/5 and tibialis anterior 4/5, posterior tibialis 4/5 and gastrocnemius 4/5. Neurological examination showed tactile dysesthesia/hyperesthesia in the distal extremities. X-ray of the left ankle was unremarkable. diagnosed reflex sympathetic dystrophy (RSD) of the lower limb and sprains and strains of the ankle. He recommended consulting a pain management specialist and the possibility of having a sympathetic block. If the patient failed to improve with the sympathetic block, a second approach would be to use selective injections most likely to the sinus tarsi within the subtalar joint and the peroneal retinaculum. The patient was prescribed Norco.

On October 5, 2011, recommended continuing care and evaluation.

On October 13, 2011, noted that the patient was still having pain in the left lower extremity of a very diffuse, non focal nature. The patient had told that the pain pattern was confusing and that there might be a subtle complex regional pain syndrome (CRPS) present and that the contribution of the lateral ligamentous trauma to her left ankle and its pain contribution could easily be confused with the overall supple pain syndrome that might be present. assessed continued pain left lower extremity with MRI findings in early August of an anterior talofibular ligament tear. had no firm answer as to the etiology of the patient's pain. He felt that the patient needed evaluation by a pain management physician in order to determine if there were subtle findings of a CRPS that had been present but nearly undetectable on clinical exam. He did not think addressing the ligamentous injury was indicated until such a time as the more diffuse pain pattern and causes had been elucidated.

On October 20, 2011, opined that the patient's current disabilities were centered around her injury which was complicated by torn ligaments, fracture and reflex sympathetic dystrophy (RSD). All of these were new and not part of a regular follow-up and management of fibromyalgia. They all were going to require a more extensive treatment, pain management and possibly surgery.

On November 4, 2011, continued modified duty and medications and recommended evaluation by a pain management physician.

On November 10, 2011, evaluated the patient for foot pain. He diagnosed RSD of lower limb and recommended continued monitoring of the progress. He

discussed with the patient on how initial symptoms had subsided about 75 to 80% since her initial injury from her fall. He advised the patient that any treatment at that time could cause a flare-up in symptoms.

In November and December, continued Soma and Vicodin, conservative treatment, increased walking and continued modified duty. He recommended awaiting ruling on the RSD.

2012: On January 11, 2012, stated that the patient had a long history of fibromyalgia. He had not made the diagnosis of RSD and it had never appeared in the past medical records over many years. It certainly was most commonly related to an injury or strain of some kind. It was most likely the RSD that arise from the injury of xx/xx/xx. The patient would require more extensive surgery and intervention and chronic treatment for severe neuropathic pain and inability to walk from RSD. It was totally unrelated to her fibromyalgia condition.

On January 18, 2012, stated that he was in agreement opinion of undergoing an ankle ligament tear repair. The patient was aware that it was possible that the RSD might worsen with invasive surgery. However, she felt that her biggest problem was the instability of her ankle. referred the patient and continued Soma and Vicodin and modified duty.

On February 2, 2012, evaluated the patient for ongoing complaints of left calcaneus fracture, RSD, lumbar strain, cervical strain and left ankle ligament tear. The patient continued to feel increasing pressure and pain in her heel. Overall, she had been using the cane more and had not been using the walker. She reported her other injuries were stable. She was also having difficulty with the insurance company to cover the RSD. The referral a couple of weeks ago had been denied as was not in the network. Examination of the left foot showed tenderness to the palpation of the calcaneus and a jerking sensation with palpation. diagnosed left calcaneus fracture, RSD, left ankle ligament tear, lumbar strain and cervical strain. He continued medications and referred the patient. The patient was placed on modified duty.

On February 2, 2012, opined as follows: Based on the patient's prolonged course, increased sensitivity and the opinions of two specialists, the patient had an RSD. Moreover, it was clearly caused by the calcaneus fracture. Thus, it was a part of her compensable injury and was caused by the initial work-related injury.

On February 16, 2012, the patient reported that over the last few weeks, she had been using the cane less and therefore she had been experiencing increased pain in her left foot. She also reported having increased pain in her left hip and right posterior knee regions. was awaiting follow-up evaluation. The patient's designated doctor evaluation (DDE) was pending. would send a letter to the adjuster explaining the importance of follow-up evaluation. He continued modified duty.

On March 6, 2012, evaluated the patient for continued pain in the ankle where she had ligament injury and pain in the heel. The pain was constant with intermittent exacerbations. The patient stated that her complex regional pain had resolved. diagnosed foot pain and felt that the patient's condition was stable and the patient should be able to have a surgery on the left heel. He recommended the surgeon to use a spinal block when he does that procedure to prevent any flare-ups of a complex regional pain type syndrome.

On March 14, 2012, noted that a couple of weeks ago the patient had been re-evaluated. had recommended an invasive treatment of the ankle if needed. He did not feel that any other treatment was needed for the RSD. Overall, the patient continued to feel some slight improvement. She reported some decrease in sensitivity of the left heel. She reported sensitivity was presently more located in the lateral ankle region. She also reported overall improvement in her right knee pain and left lower back pain. She continued to have some left upper back pain but that seemed to be stable from the last visit. Her DDE was still pending. Examination of the left foot showed mild tenderness to palpation of the calcaneus that seemed to be improved since the last visit. continued modified duty and referred the patient to an orthopedic foot and ankle specialist.

On April 12, 2012, the patient was seen in a follow-up for her left calcaneal fracture, RSD and left ankle ligament tear. The patient reported having a designated doctor's evaluation approximately 10 days prior. She complained of ongoing pain in the left ankle and heel region. She tried not to use the cane at home and did feel some increased pain and increased back and neck pain without using the cane. She also felt some instability to the ankle and pain worsening throughout the day. The patient had not yet received the designated doctor's evaluation and had not heard about the referral to see an orthopedic foot and ankle specialist. assessed left calcaneus fracture, RSD and left ankle ligament injury and was awaiting report from designated doctor. He recommended follow-up in one month.

On May 1, 2012, noted that the patient had seen an orthopedic foot surgeon the previous day and had an injection in her left ankle. The patient reported having some increased pressure pain after the injection. According to the patient, wanted to perform a CT given that there were some signs of arthritis on the x-rays that was taken on the previous day. Based on the CT scan, he wanted to determine his future treatment recommendations. The patient reported that she was scheduled for a designated doctor visit on the following week to determine if she was at maximum medical improvement (MMI). She had a designated doctor visit approximately one month ago for extent of injury determination. The designated doctor concluded that it did include the ligament tear. However, in the doctor's opinion, RSD was not a compensable diagnosis. The patient also complained of left earache that she had approximately one-and-a-half weeks ago. It was intermittent prior to that. She reported not having any ear pain for the last three-to-four days. She was concerned about that because she was told by her primary care physician (PCP) that it could be due to trigeminal neuralgia given that the ear exam was normal. She was also concerned due to possible

correlation of trigeminal neuralgia with RSD. He was in disagreement with the designated doctor findings that it was not a compensable injury. He recommended the patient should receive a letter explaining the details of her RSD symptoms. felt that the patient was not at MMI and she needed further care for possible repair of her ankle ligament tear.

On May 7, 2012, wrote a letter of rebuttal opinion of extent of injury. disagreed that the only compensable injury was the ligament tear. He felt that the compensable injuries were the fractures of the calcaneus and into the middle facet subtalar joint, RSD and right thigh paresthesia.

On May 7, 2012, performed a designated doctor evaluation (DDE). Following additional information was noted: *On August 11, 2011, MRI of the left knee showed a tiny Baker's cyst; small localized area of soft tissue edema in the prepatellar region without a true bursal fluid collection. On August 11, 2011, MRI of the left calcaneus showed disruption of the anterior talofibular ligament; localized area of marrow edema within the mid body of the calcaneus that could be the result of a bone contusion. On August 18, 2011, EMG/NCV study of the lower extremities showed evidence of a left superficial fibular neuropathy given the lack of recruitable SNAP. The injury could result from a traction injury to the nerve at the ankle which might have occurred during her fall. The motor components of the fibular nerve were all within normal limits.* opined as follows: The patient could work with restrictions. The extent of injury would include left anterior talofibular ligament disruption, left calcaneus fracture, posttraumatic left subtalar arthritis, left trapezius strain, left shoulder contusion, left hip contusion, left knee contusion, right foot contusion and right thigh/groin paresthesia (resolved). There was no clinical evidence of RSD/CRPS. The patient had not reached MMI and continued treatment program for anterior talofibular ligament disruption after assessment by an orthopedic specialist was recommended.

On May 15, 2012, MRI of the left ankle without contrast revealed: (1) Bony contusion and likely trabecular microfracture above the talar neck. No calcaneal fracture or contusion was present. (2) Remote appearing partial thickness tear of the anterior talofibular ligament. (3) Peroneus brevis degenerative tendinopathy.

On May 15, 2012, CT of the heel without contrast was performed in comparison to the MRI on the same day. This did not show any fracture. However, the comparison MRI from the same day demonstrated a trabecular microfracture and contusion of the talar neck, which was not well evaluated with CT imaging. (2) There was osteopenia. (3) Degenerative flattening of the peroneus brevis.

On May 15, 2012, MRI of the right hip revealed: (1) Mild right hip osteoarthritic changes without acute abnormality identified. (2) Mild gluteus medius and maximus degenerative tendinopathy and common hamstring degenerative tendinopathy.

On May 17, 2012, saw the patient who continued to do poorly with moderate-to-severe, dull, aching, throbbing pain throughout her left ankle and leg, making it

extremely difficult to stand, walk, function or do any activities. She required a quad cane for ambulation. She had morning stiffness lasting throughout the day and continued to have swelling, pain, paresthesias, weakness and limitation of the left foot, ankle and leg. The patient had not improved with medications and continued to have general mild-to-moderate pain throughout her fibromyalgia points through her spine and extremities. Her current medications included hydrocodone, Soma, vitamin D, alphasipoic acid, applesider vinegar, digestive enzymes, multivitamins, B-complex, aloe-vera capsules, energy greens and Noni juice. History was positive for vitamin D deficiency on supplements; hyperlipidemia under treatment; RSD left lower extremity, which had been recommended for some corrective surgery, but not yet approved. Review of systems (ROS) was positive for fatigue, easy bruising, sensitivity to sunlight, neck pain, back pain, joint pain, anxiety, insomnia, imbalance, weakness of the left ankle; paresthesias, sweating, discoloration and swelling of the left ankle. Examination revealed some mild erythema and some mild swelling of the foot and ankle with severe tenderness and pain and some moderate limitation of the left ankle. There was no swelling or limitation of the hands, wrist, elbows, shoulders, hips, knees, right ankle and right foot. There was some mild tenderness through the paraspinal muscles and extremities. On neurological examination, there was weakness of the left foot and hyperesthesias of the left foot and ankle. The patient had difficulty getting up from chair and ambulated with limp and pain favoring the left foot and ankle. She used a quad cane for ambulation. assessed fibromyalgia with mild activity, controlled long-term over the years, left lower extremity pain, paresthesias and evidence of RSD which the patient had never had in the past, except after the injury this past year. The left lower extremity pain and difficulty were strictly part of the RSD and not related at all to her fibromyalgia. Fibromyalgia did not involve the foot and ankle. It was characterized by tender points more proximal and spinal. The patient had fibromyalgia for many years without any trouble with a general ability to walk. This condition looked limiting and disabling for the patient and now was strictly related to her injury which resulted in an RSD situation. She had not improved despite maximum medical treatment and the only hope for improvement was through surgery. recommended continuing current supportive care, medications and treatment and proceeding with corrective surgery as soon as it was approved. He recommended recheck with himself in three to four months.

On May 22, 2012, EMG/NCV showed the following findings: (1) There was a borderline mild right median neuropathy at the wrist. (2) There was a small disc extrusion at the right L3-L4 level on MRI which correlated with the right thigh numbness. There were no findings of a lumbar radiculopathy affecting the motor nerve roots but this disc extrusion might be causing a sensory radiculopathy which was not typically detected with EMG/NCV testing.

On May 30, 2012, noted that the patient had undergone a DDE which had found her not at MMI. The designated doctor had sent her for a CT of the left heel and MRI of the left ankle. The MRI of the left ankle showed a bony contusion and likely trabecular microfracture of the talar neck. It was apparent that the calcaneal fracture had resolved. She also had a partial thickness tear on the posterior

trabecular ligament. She had not seen again. The patient continued with her pain in the left heel that she described as a pressure type of pain and had been using a pronged cane but she did walk around without the cane while at home. She continued with some neck pain that radiated to the lateral scapula and seemed to be a little worse than the last visit. She reported that her lower back pain had been doing well. On examination of the left ankle, there was no edema. There was moderate tenderness on the lateral aspect extending to the forefoot region. There was negative anterior drawer's sign and there was slight decreased dorsiflexion and plantar flexion which seemed to have improved from previous visit. Examination of the neck showed full ROM and mild TTP in bilateral paraspinal muscles on the inferior aspect of the neck. assessed left talus fracture, left ankle ligament tear, RSD, cervical strain and healed left calcaneal fracture. He stated that given the fact that the patient was found not at MMI and the MRI findings of the talar fracture, the patient needed evaluation to find out what further treatment was needed at that point of time. He advised the patient to continue medications, modified duty and follow-up in one month.

On June 27, 2012, noted that the patient had moderate tenderness to palpation in the lateral aspect extending to the anterior talofibular ligament. There was decreased dorsiflexion and plantar flexion. He recommended follow-up, continuing modified duty and follow-up with him in one month.

On July 26, 2012, the patient had increased pain on her left heel and foot area. She had a short leg cast fixed the previous week. She reported that since then the pain had worsened specially over the past three days. She was currently out of pain medications. refilled Vicodin, continued modified duty and advised follow-up for worsening pain.

On August 15, 2012, noted the patient was doing poorly with moderate-to-severe, throbbing, aching pain through her left ankle and heel with poor healing. He reported that the patient had been recommended Miacalcin nasal spray, but this caused some floaters in her eyes and visual disturbance. So she had to stop it. She had not been approved for any further corrective surgery for the left ankle but would be getting another opinion. The patient required occasional small doses of hydrocodone for pain relief along with occasional Soma compound. She remained on her supplements and was undergoing eggshell therapy as well. She was extremely limited in standing and walking and being active and was becoming quite miserable. Review of systems (ROS) was positive for some visual changes, blurred vision and sensitivity to sunlight, diffuse pains in her body, some weakness, nocturia and cold intolerance. Examination showed severe tender points throughout the paracervical and parathoracic muscles and sacroiliac (SI) joints. There was some swelling, pain, tenderness, limitation of motion of the right knee in the popliteal fossa. assessed fibromyalgia, chronic pain syndrome, RSD left lower extremity with poor healing and chronic pain and recommended considering conservative care. He stated the patient remained disabled at that point with her condition and she should make sure that she stayed on vitamin D and continued her pain control as needed. He also advised the patient to have

her vitamin D levels checked to make sure how her supplement therapy was going and recommended follow-up in four months.

On August 21, 2012, the patient reported that she had a follow-up. Apparently, the cast was removed and she was placed in a new cast. She continued to have pain. Examination showed some mild edema but no erythema. She walked with a significant limp to the left and used a cane. assessed left talus fracture, left ankle ligament tear and RSD. He strongly felt that the brace that had ordered and PT should have been approved.

On September 12, 2012, performed a post designated doctor required medical evaluation (PDDRME). He noted the following: *The patient had a significant prior history related to this compensable injury in the form of lower back injury that resulted in lumbar disc injury at L4-L5 and cervical fusion. Surgery outside the compensable injury included having a prior cervical fusion. X-rays of the cervical spine dated March 23, 2011, revealed stable anterior fusion and discectomy from C5 through C7 and stable mild canal narrowing with effacement. X-rays of the left shoulder dated March 3, 2011, revealed mild spurring of the acromioclavicular (AC) joint without acute osseous findings; surgical changes involving the left axilla and cervical spine. X-rays of the scapula dated March 3, 2011, revealed no acute osseous findings. X-rays of the pelvis dated March 3, 2011, revealed mild degenerative changes. MRI of the cervical spine dated March 3, 2011, revealed degenerative changes; small disc extrusion at L3-L4; posterior annular tear at L4-L5 without protrusion; mild canal narrowing at L3-L4; and no acute findings. Electrodiagnostic studies dated August 18, 2011, revealed superficial fibular neuropathy sensory only. Electrodiagnostic studies dated August 8, 2011, revealed right carpal tunnel syndrome (CTS). MRI of the right hip dated March 3, 2011, revealed osteoarthritic changes without acute abnormality and mild gluteus medius and minimus degenerative tendinopathy. MRI of the heel dated January 15, 2012, revealed no fracture. MRI of the left ankle dated May 15, 2012, revealed bony contusion and likely trabecular microfracture talar neck, no calcaneal fracture or contusion and partial thickness tear of the anterior talofibular ligament, and peroneus brevis degenerative tendinopathy. in the course of treatment noted that the patient was treated initially at emergency room (ER) followed on February 23, 2011. The patient was found to have left foot calcaneus fracture. reported in that visit that the patient's only complaint was pain and swelling in her left foot and ankle. She subsequently initiated the treatment followed. The diagnosis expanded to include neck and lower back pains/strains, bilateral hip contusions, shoulder pain and right knee contusion. The patient was subsequently referred to several specialists for a left ankle/foot including. At that point of time, the other injured body parts were not accepted as a part of these compensable injuries nonetheless had resolved. had determined the patient had an extra-articular calcaneal fracture to the left foot with an AFTL tear. She was treated conservatively. On October 13, 2011, stated that he did "not have a firm answer as to the etiology of a pain". He recommended pain management consult. Both diagnosed the patient with signs of RSD. concluded that the patient was a candidate for ATFL reconstruction "once her RSD was better."*

opined that the patient had not reached a point of clinical MMI and therefore an impairment rating (IR) was not indicated. Once the cast was removed, the patient needed to continue conservative treatment under to address her talar fractures and peroneal tendinosis. Treatment could include physical therapy (PT) and use of an AFO brace. The compensable injury included the calcaneal fracture which had healed the AFTL rupture, the talus micro trabecular fracture and RSD which had resolved.

On October 4, 2012, noted that the patient had some decrease in temperature changes and sensations that she was feeling with the RSD earlier. The patient also wanted to make note that when she was on the course of Miacalcin that was prescribed she did develop some floaters, flashes and blurred vision. She had seen an ophthalmologist for this and had some improvement. recommended contacting the adjuster to check on the update on the status of the patient and her treatment and recommended follow-up.

On October 25, 2012, the patient reported that she was comfortable in the cast. Examination of the left lower extremity showed some dependent rubor and some mild swelling of the left foot. recommended wearing a fracture boot until the patient was fitted with a brace.

On November 19, 2012, the patient returned for a follow-up of bracing for treatment of micro trabecular fractures involving the majority of her left talus including the left talar head, neck, body and tendinosis of her peroneus brevis tendon with interstitial tearing. He noted that the patient had problems including displacement of cervical and thoracic or lumbar intervertebral disc without myopathy since December 8, 2006; rupture of tendon, non traumatic, other tendons of foot and ankle; stress fracture of other bone and closed fracture of calcaneus. Examination revealed that the patient's AFO had been fabricated and appeared to be approximately fashioned. She still had some discomfort ambulating in the AFO and her pelvis was not level. believed that one cm lift to the sole of her right shoe would level her pelvis so as not to cause problem with her hips and back. Examination of the left lower extremity showed tenderness much as previously described over the peroneal tendons and over the head, neck and body of the talus with associated swelling present. He assessed stress fracture of other bone and rupture of tendon, non-traumatic; other tendons of foot and ankle. Micro trabecular fractures involving the majority of her left talus including the head, neck and body approximately controlled in her AFO. There was tendinosis of the peroneus brevis tendon with interstitial tearing which continued to be symptomatic and history of non-displaced fracture of the left calcaneus fracture after fall at hospital on xx/xx/xx. He advised the patient to go back and see the brace maker and have him make adjustments so that her pelvis was leveled and to wear the brace for all weightbearing activities. allowed her to return to light duty work only in her AFO and recommended follow-up in three months.

On December 5, 2012, the motor and sensory nerve conduction study was performed but the report is incomplete.

2013: On January 17, 2013 evaluated the patient for the left foot complaints. The patient was previously seen in November when she was suggested modifications made to the AFO. Unfortunately, over the past two weeks she had increasing pain over the lateral foot. The patient reported that the pain was worse than it had been in the past, but in the same area. She was not able to wear her brace on several occasions. She continued to have anteromedial ankle pain which was stable. Examination showed exquisite tenderness along the peroneus brevis tendon. She was mildly tender over the anteromedial talus. There was mild persistent edema. X-rays of the left ankle showed no fracture or dislocations and no interval changes from the x-rays from July of last year. assessed microtrabecular fractures involving the majority of the left talus including the head, neck and body and tendinosis of peroneus brevis tendon with interstitial tearing which was persistently symptomatic. recommended returning to discuss her surgical options. The patient was to continue with the ankle foot orthosis (AFO).

On January 21, 2013 evaluated the patient for continued severe pain in the lateral aspect of her left foot. noted that the patient had significant relief with PT. The patient reported that she had her AFO adjusted several times, but after she wore the AFO for a short period of time the lateral aspect of her left leg and foot would become completely numb. She still had pain if she tried to walk in the AFO. MRI showed that she had micro-trabecular fractures involving majority of left talus including the head, neck and body and also tendinosis of her peroneus brevis tendon with some interstitial tearing. Sural nerve was blocked about 3½ inches above the tip of the lateral malleolus. Examination of her AFO showed what appeared to be appropriately fashioned and there was not a blurring problem in the AFO. assessed tendinosis left peroneus brevis tendon with interstitial tearing—suspected progression of tendinosis, microtrabecular fractures involving the majority of the left talus including the head, neck and body. recommended second look at the patient's peroneal tendons and also the lateral forefoot as the lidocaine injection proved that there was no involvement of her sural nerve. ordered MRI of the left peroneal tendon and foot. He opined that it was quite possible that the brace was aggravating the patient's pain. The patient was going to use her wheelchair.

On March 6, 2013, reported that had tried an injection of nerve block on the patient's ankle which had helped initially; however, the pain returned shortly afterwards and she did not have any significant improvement. Because of this, a peroneal tendon injury was suspected and an MRI of the ankle to evaluate this was ordered. She continued wearing the brace, which helped but she still had significant pain especially at the end of the day. At times, she used her wheelchair at the end of the day given the amount of pain she had. She also had occasional coolness and mottling of the ankle and foot region. She also noted that she had her statutory MMI on February 26, 2013. On examination, there was significant atrophy of her calf muscles. There was slightly decreased ROM of her ankle. There was moderate tenderness to palpation on bilateral malleolus as well as bilateral hind foot and midfoot regions. requested records office to review treatment and plan and recommended follow-up as needed.

On March 21, 2013 performed a DDE and assessed statutory MMI as of February 26, 2013, with 15% whole person impairment (WPI) rating. The extent of injury included left calcaneus fracture, left talus fracture, left peroneus brevis tendinopathy, left anterior talofibular ligament tear, left peroneal neuropathy, left scapular/shoulder contusion and left hip contusion.

Per IRO report dated March 25, 2013, the request for MRI ankle and MRI foot without contrast was authorized.

On March 27, 2013, MRI of the left ankle revealed: (1) Peroneus brevis tendinopathy, with flattening in the level of the distal fibula and suspected partial thickness tear distal to the fibular tip. (2) Interval resolution of microtrabecular fracture and bone contusion of the talus, with no residual fracture deformity or articular surface defects. No evidence of calcaneal fracture. (3) Small tibiotalar joint effusion.

On April 2, 2013, EMG/NCV of the upper and lower extremities revealed the following: (1) Needle EMG was again difficult to assess due to poor activation of the muscles and inconsistent contraction of the muscles. (2) Since the previous EMG there had been development of a mild sensory ulnar neuropathy. (3) There was evidence of subacute denervation in the left extensor hallucis longus (EHL). There were no other findings to suggest a peroneal neuropathy or an L5-S1 nerve lesion. Recommended determining if the brace was causing compression across the muscle leading to localized muscle damage. (4) The atrophy in the left lower extremity was most likely due to disuse. The patient stated that she had been wearing a brace since June.

On April 10, 2013, noted that the patient complained of moderate, sharp aching pain through her left lower extremity as well as some moderate chronic long-term pain to her neck and back. She had not been able to work or function at all due to the left leg pain. Any physical activities tend to aggravate her condition. Stress made it worse. Morning stiffness would last only a few minutes daily. She was relying on her supplements rather than prescription medications. Musculoskeletal examination showed that the patient was ambulating slowly with some pain and minor limp. She was wearing a left lower extremity orthopedic boot. There were moderate tender points at the paraspinal muscles extremities and custom her junctions in all FM areas. diagnosed fibromyalgia/myofascial, chronic pain, RSD of left lower extremity and vitamin D deficiency. For fibromyalgia/myofascial, he recommended continuing conservative care and avoidance of straining and stretching, exercises as tolerated and continuing her supplements. For RSD of the lower limb, he recommended surgery recommended by other physicians as she had failed conservative care. In regards to her vitamin D deficiency, he recommended continuing supplement.

On April 16, 2013 a gastroenterologist in his letter stated that he had worked with the patient for over ten years and she had no issues with mobility until recently

when she started having difficulty ambulating, walking with pain and an obvious limp (wearing a boot) and this was not a long standing disability.

On the same day a gastroenterologist stated that the patient was never hindered by any injuries or RSD and did not miss any work.

On May 16, 2013, performed a left partial excision of calcaneus for postoperative diagnoses of status post left calcaneal fracture with prominent bone at the fracture line, lateral wall and left calcaneus and left tendinitis/tendinosis, peroneal tendons.

On June 3, 2013, a PT referral was made for independent pool program and warm pool.

Per utilization review dated July 5, 2013, the request for independent pool program, warm pool/Health Club membership was denied with the following rationale: *"The last clinical note was an operative report from May 16, 2013. There is no post-operative assessment. There is no post-operative SOAP note. There is no treating orthopedic note. Patient's post-operative status is entirely unknown and not documented. Also unclear why a pool program is being requested since this is generally a recreational activity not a rehab activity. Also, it is not known the duration of this treatment request and whether or not this is supervised or unsupervised. I spoke and the case was discussed. He told me that the patient is still in a post-operative fracture boot. felt that he aggravated her RSD with the surgery he performed. indicated that the patient is in too much pain to begin formal post-operative PT and would not benefit from it at this time. Recommendation remains adverse. The patient should first complete a course of active post-op rehab when feels that she is ready."*

On July 11, 2013, a request for reconsideration of independent pool program, warm pool/Health Club membership was submitted. It was stated that the medical records established the clinical indication and necessity of this treatment. The goal of this reasonable and medically necessary treatment which was consistent with the ODG and was to provide pain relief, increase performance in the activities of daily living, reduce symptoms and reduce medication use.

Per reconsideration review dated July 17, 2013, the appeal for independent pool program, warm pool/ Health Club membership CPT placed as S9970 was denied with the following rationale: *"The Attorney assertion that ODG endorses independent pool and gym membership is not accurate. Recommended is re-visiting ODG. The deficiencies in reporting of post-operative physical therapy to date is not responded to. Regarding Reconsideration: Independent Pool Program, warm pool/ Health-Club membership, ODG does not recommend gym memberships unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. In addition, treatment needs to be monitored and administered by medical professionals. However, there is no evidence that attempts at home exercise were ineffective. There is no evidence that the patient would require specialized equipment. There is also no indication that treatment will be*

administered and monitored by medical professionals. In addition, gym memberships, health clubs, swimming pools, athletic clubs, etc., are not generally considered medical treatment. Recommend non-certification.”

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

I agree that an independent pool program with gym membership is a reasonable alternative if a home exercise program has failed per ODG. Unfortunately there is no documentation where post operative rehabilitation or home exercise program has been attempted and failed. Therefore, based on ODG the request was denied and should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES