

<b>Case Number:</b>	CM13-0035913		
<b>Date Assigned:</b>	03/19/2014	<b>Date of Injury:</b>	01/10/2012
<b>Decision Date:</b>	04/25/2014	<b>UR Denial Date:</b>	09/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2013

### 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. The expert reviewer is Board Certified in Podiatrist 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 58-year-old female who reported an injury on 01/10/2012. The mechanism of injury was noted to be that the patient was jumping up to reach a metal rack and landed on her left ankle, and she twisted it and fell. The patient's diagnosis was status post open reduction and internal fixation (ORIF) of the left ankle. The patient was noted to have an MRI on 10/26/2012 and 08/13/2012. The documentation of 10/09/2013 revealed that the patient had a prior MRI which was with findings consistent with postsurgical changes in the navicular bone, most noted secondary to the posterior tibial tendon repair and thickened soft tissue around and in between the posterior tibial tendon and the flexor digitorum longus. Flexor digitorum longus tenderness was noted. There was a loss of fat in the sinus tarsi. The extensor and peroneal tendons were unremarkable. All other findings were within normal limits except for a 3.2 cm lipoma in the inferomedial aspect of the foot, superficial to the abductor hallucis muscle. The physician indicated that the findings of the MRI were consistent with the physician's findings. The patient had a continuation of pain from the midfoot distally to the big toe. Neurologically, it was noted that the patient had hypersensitivity as well as a loss of sensation in the left foot. It was indicated that the patient demonstrated no significant interval improvement. The patient had pain to palpation and range of motion. The patient walked with a cane and had no functional restoration of gait. The muscle testing was +5/5 of the extrinsic and intrinsic musculature. It was within normal limits in all muscle groups controlling dorsiflexion, plantar flexion, inversion and eversion. The diagnoses were noted to include status post repair of the posterior tibial tendon on the left ankle, status post arthroscopic surgery of the left ankle, status post tendon transfer, failed surgery to the left ankle and left foot and painful gait. The recommendation was for an MRI of the left foot.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI OF LEFT FOOT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, 14, page 374

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENT MEDICINE (ACOEM) AND OFFICIAL DISABILITY GUIDELINES (ODG).

**Decision rationale:** The Official Disability Guidelines recommend a repeat MRI when there is a significant change in symptoms and/or findings suggestive of a significant pathology. The clinical documentation submitted for review indicated that the patient's neurologic complaints were not corroborated by the clinical examination as the muscle testing was +5/5 of the extrinsic and intrinsic musculature and they were within normal limits in all muscle groups. There was a lack of documentation indicating that the patient's findings were a significant change or findings suggestive of a significant pathology. Given the above, the request for an MRI of the left foot is not medically necessary.