

<b>Case Number:</b>	CM13-0066709		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	12/12/2011
<b>Decision Date:</b>	05/19/2014	<b>UR Denial Date:</b>	12/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### 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 Orthopedic Surgery 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:

This 57-year-old diabetic male presented on 11/11/13 for initial podiatric surgical consultation of left great toe hallux-valgus and second toe hammertoe deformity. He underwent a left total knee arthroplasty on 5/10/13 (for end-stage osteoarthritis) and was having difficulty ambulating due to the deformities of his left toes. Orthopedic surgical records document intermittent examinations of the left foot/toes from 1/8/13 to 10/1/13 with no prior indications of an open wound. The 11/11/13 exam findings documented left big toe tenderness and edema with erythema. An open wound was noted on the plantar aspect measuring 1 x 1 x 0.5 cm with a red granulation base and no undermining. The wound probed to the soft subcutaneous tissue with no active drainage or bleeding noted. The toenail was loose at the base. Pulses were weak, capillary refilling time was delayed, and protective sensation was decreased. X-rays of the left foot showed degenerative changes at the metatarsophalangeal joint and interphalangeal joint of the left hallux. X-rays of the second MPJ showed a partially healed avulsion fracture of the navicular, located dorsally. Meticulous wound care with Silvadene was recommended. A MRI of the left foot was requested to rule-out osteomyelitis of the left hallux with findings of significant edema, erythema, and open wound.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI OF THE LEFT FOOT WITHOUT CONTRAST:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Ankle & Foot (Acute & Chronic). Additionally, American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, Chapter 14.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot, Magnetic Resonance Imaging (MRI).

**Decision rationale:** The request under consideration is for a left foot MRI without contrast. California MTUS guidelines are silent with regard to the requested procedure. The Official Disability Guidelines indicate that MRI imaging for the foot may be supported following a trial of conservative treatment. Records suggest that the left foot wound is an acute finding with no bone exposure. There is no documentation that conservative wound management and antibiotic therapy have been tried and failed. Guidelines criteria have not been met at this time. Therefore, this request for a left foot MRI without contrast is not medically necessary at this time.