

Case Number:	CM14-0164742		
Date Assigned:	10/09/2014	Date of Injury:	03/12/2012
Decision Date:	11/10/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/07/2014

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:

The patient is a 25 year old male who was injured on 03/12/2012 when he was involved in a motor vehicle accident. Prior treatment history has included Zoloft, Xanax, Percocet, Lunesta, Ambien, Restoril, Butrans patch, and physical therapy sessions. The patient underwent 6 surgeries to bilateral feet from 2012 to 2013. CT scan of the left foot dated 09/27/2013 revealed evidence of multiple injuries to the ankle and foot. There is diffuse disuse osteopenia. There is an un-united fracture of the base of the second metatarsal despite the presence of internal fixation bridging the fracture line. There is mild degenerative disease at the first tarsal-metatarsal joint. Progress report dated 07/03/2014 documented the patient to have complaints of bilateral foot pain, left greater than right. He rated his pain as 8/10 and stated his feet swell daily. He also reported the pain is worse with walking and activities but is alleviated with medications and elevating his feet. Physical examination revealed severely decreased and painful range of motion in bilateral ankles. He utilizes crutches for ambulation. There were no other significant findings documented on exam. The patient is diagnosed with bilateral ankle/foot pain status post multiple ORIF's secondary to traumatic injury in 2012. Progress report dated 09/10/2014 documented the patient to have complaints of left foot and ankle pain. The patient had received an injection to his left ankle which provided 30% relief of his pain. He reported the pain is most prominent at the area of his hardware. He rated his pain to be 6/10 with burning and aching. This patient was recommended for ankle arthroscopy, removal of painful hardware, and exostectomy of the plantar 5th metatarsal head in an attempt to relieve the patient of his pain. Prior utilization review dated 09/26/2014 states the request for Associated Surgical Service: Pre-Op clearance (history & physical, EKG, chest X-ray, labs) is denied as there is no medical history indicating the need for preoperative clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Pre-Op clearance (history & physical, EKG, chest X-ray, labs): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation The Official Disability Guidelines (ODG), Ankle & Foot

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back, preoperative testing

Decision rationale: The ODG recommends ECG for high risk surgical procedures and intermediate risk surgical procedures if there is an additional risk factor. It also states that (The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings).The medical records on a progress report dated September 4, 2013 document the patient to be clear of any cardiovascular, respiratory, genitourinary, or gastrointestinal problems. Further, the documents show the patient to be of young age. Based on the ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.