

Case Number:	CM14-0042533		
Date Assigned:	06/30/2014	Date of Injury:	05/16/2013
Decision Date:	08/05/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	04/09/2014

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 Podiatric Surgery and is licensed to practice in New York. 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:

According to the enclosed information, the original date of injury was 5/14/2013. This patient was evaluated by her physician on 1/15/2014. The patient continues to complain of right ankle pain, unresponsive to cortisone injection. It appears that patient has been authorized for functional foot orthotics. Physical exam reveals no edema, no erythema, no ecchymosis to the foot. (The progress note states that patient is there for right ankle pain, but the examination states left ankle exam.) Pain is noted to the medial lateral and anterior ankle. Pain is noted upon dorsiflexion and plantar flexion of the foot, causing an antalgic gait. Muscle strength is 5/5, and neurologic sensation is intact to the lower extremities. The MRI was positive for an osteochondral lesion at the medial talar dome with chondral fissuring of the subchondral cyst measuring approximately 7 mm at the anterior posterior by 5 mm to the lateral consistent with history of previous injury. Scarring of the calcaneal fibular ligament with spurring at the inferior fibular margin at its attachments and also scarring of the deltoid ligament and chondral fissuring with subchondral edema at the medial tibial plafond, and mild tendinosis with thickening of the medial plantar fascia consistent with plantar fasciitis. A diagnosis of left ankle sprain with plantar fasciitis with subchondral lesion and osteochondral lesion of the medial talar dome is noted. The patient was given a prescription for pain medication, advised to use Voltaren gel to the painful area, casted for custom orthotics, and advised to consider surgical intervention if necessary. During a visit on 2/12/2014 it is noted that patient continues to have right ankle pain. Because patient is still having pain, and the doctor would like to remain conservative wire to ankle arthroscopy, he recommends a CT scan. The doctor advises that he would like this CT scan to rule out any other loose bodies in the joint that could be causing the pain. The doctor feels that the pain noted by this patient is out of proportion to the MRI findings

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan - right ankle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 372-374.

Decision rationale: After careful review of the enclosed information and the MTUS guidelines pertinent in this case, it is my feeling that the decision for a CT scan of the right ankle is not medically reasonable or necessary at this time. Chapter 14 of the guidelines states that: With regards to special studies and diagnostic treatment considerations: For most cases presenting with true foot and ankle disorders, special studies are usually not needed until after a period of conservative care and observation. Most ankle and foot problems improve quickly once any red-flag issues are ruled out. Routine testing, i.e., laboratory tests, plain-film radiographs of the foot or ankle, and special imaging studies are not recommended during the first month of activity limitation, except when a red flag noted on history or examination raises suspicion of a dangerous foot or ankle condition or of referred pain. In particular, patients who have suffered ankle injuries caused by a mechanism that could result in fracture can have radiographs if the Ottawa Criteria are met. This will markedly increase the diagnostic yield for plain radiography. The Ottawa Criteria are rules for foot and ankle radiographic series. An ankle radiographic series is indicated if the patient is experiencing any pain in the: Malleolar area, and any of the following findings apply: a) tenderness at the posterior edge or tip of the lateral malleolus; b) tenderness at the posterior edge or tip of the medial malleolus; or c) inability to bear weight both immediately and in the emergency department. Midfoot area, and any of the following findings apply: a) tenderness at the base of the fifth metatarsal; b) tenderness at the navicular bone; or c) inability to bear weight both immediately and in the emergency department. Radiographic evaluation may also be performed if there is rapid onset of swelling and bruising; if patient's age exceeds 55 years; if the injury is high velocity; in the case of multiple injury or obvious dislocation/subluxation; or for patients with continued limitations of activity after four weeks of symptoms and unexplained physical findings such as effusion or localized pain, especially following exercise, imaging may be indicated to clarify the diagnosis and assist reconditioning. Stress fractures may have a benign appearance, but point tenderness over the bone is indicative of the diagnosis and a radiographer a bone scan may be ordered. Imaging findings should be correlated with physical findings. Disorders of soft tissue (such as tendinitis, metatarsalgia, fasciitis, and neuroma) yield negative radiographs and do not warrant other studies, e.g., magnetic resonance imaging (MRI). Magnetic resonance imaging may be helpful to clarify a diagnosis such as osteochondritis dissecans in cases of delayed recovery. According to the progress notes this patient has already had an MRI of his ankle, noting an osteochondral lesion at the medial talar dome with chondral fissuring of the subchondral cyst measuring approximately 7 mm at the anterior posterior by 5 mm to the lateral consistent with history of previous injury. Scarring of the calcaneal fibular ligament with spurring at the inferior fibular margin at its attachments and also scarring of the deltoid ligament and chondral fissuring with subchondral

edema at the medial tibial plafond, and mild tendinosis with thickening of the medial plantar fascia consistent with plantar fasciitis. This exam appears to be sufficient and would certainly also show any bony loose bodies within the joint. The guidelines above also states that special studies are not needed until after a area of conservative care. Patient was just receiving their orthotics as the recommendation for the CT was placed. Patient should undergo orthotic usage for at least two months prior to initiating another special study, in particular the CT scan. Therefore, the request for CT scan - right ankle is not medically necessary.