

Case Number:	CM14-0080032		
Date Assigned:	07/18/2014	Date of Injury:	10/14/2013
Decision Date:	09/17/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/30/2014

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 Occupational Medicine 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 is a 55-year-old man with a date of injury of 10/14/13. The patient reportedly stumbled over a vacuum cord and twisted the right ankle, right knee and back. He was initially seen in the Emergency Department with radiographs of the foot showing a possible old avulsion injury of the medial malleolus. No evidence of acute fracture. He was given Tylenol with Codeine. He was returned to regular work. He was then treated in an outpatient clinic where PT was prescribed and he was given Tylenol with codeine on 10/21/13. He was later prescribed chiropractic treatment, MRI of right foot ankle and knee was requested and an orthopedic evaluation was requested. Patient continues regular work. A 4/21/14 report indicated that the patient had had PT and completed chiropractic treatments. His low back pain was reportedly 0, there was occasional clicking with no pain in the right knee. Primary complaint was pain in the right foot, rated 3/10. No mention of location. That report indicated that there had been an MRI done of the right knee but it did not mention an MRI of the right foot. Examination documented that day indicated that there was pain between the TMT joints of the 1st and 2nd toes. Ankle has full range of motion. Fine motor control of toes was intact, inversion, eversion, dorsiflexion and plantar flexion. Patient was given a refill, tylenol 650 mg, continue on regular work and a podiatry consult was requested. There is an MRI of the right foot dated 2/16/14 with an impression of findings compatible with osteoarthritis of the hallicus sesamoid complex. MRI of the ankle the on same date showed findings compatible with an old tear and fibrosis of the anterior talofibular ligament. There is a mild ankle joint effusion with synovial thickening and osteoarthritis of the ankle. A 5/19/14 medical report indicates that the patient's pain level waxes and wanes, at its peak it is 6/10 and is primarily in the right foot. Examination was unchanged from the 4/21/14 report. Patient has continued with regular work. There no mention of the type of shoes this patient routinely wears at work or off the job.

IMR ISSUES, DECISIONS AND RATIONALES

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

Podiatry Consult for Right Foot: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 362, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Pain Procedure Summary (last updated 04/10/2014).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-377. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 7, page 127.

Decision rationale: At the time of this request this injury was about 5 months old and subacute. There had been appropriate conservative treatment with some residual pain in the foot but no description of any activity limitations as a result of that pain. Radiographs and MRI did not show a surgical lesion and there is no red flag. ACOEM guidelines state the referral for surgical consultation is indicated when patients have activity limitations for more than one month without signs of functional improvement which is not the case here. There is no description of loss of range of motion or strength and no evidence of a lesion that would benefit from surgical intervention. Thus, based on the evidence and the guidelines this request is not considered to be medically necessary.