

Case Number:	CM14-0001836		
Date Assigned:	01/22/2014	Date of Injury:	12/29/2012
Decision Date:	01/19/2015	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/06/2014

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 Family 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 40-year-old food service team member reported injuries to her right ankle and low back after slipping and falling at work on 12/29/12. She has a history of a previous right wrist and shoulder injury in 2000, which had been settled. Initial treatment for the current injury was conservative, with medications, splinting and physical therapy. When she did not improve as expected, an MRI of the right ankle was performed on 4/5/13 which revealed a healing, non-displaced fracture of the posterior malleolus of the tibia, without significant bone marrow edema or osteochondral defect. There was also a small effusion, thinning of the ATF ligament, mild tendinosis of the peroneus brevis and tibialis posterior tendons, and minimal edema of the deltoid ligament. The patient was referred to an orthopedist, which ultimately referred her to a podiatrist when she did not improve despite extensive physical therapy. The podiatrist placed her in a cast. The records contain a single report from the patient's current treater, an orthopedist, dated 11/8/13. According to his report, the patient stated that she had been in a cast for 6 weeks, that the podiatrist had been overly aggressive while removing the cast, and had injured her right ankle and foot in the process. She continues to have pain in her right ankle as well as numbness in her right foot. She is unable to bear weight on her right foot, and is unable to lift any weight at all. On exam, the patient is noted to be extremely obese (BMI 41.7). Her right shoulder is tender, with weakness and limited range of motion, with similar findings in her right wrist. Tinel's and Phalen's signs were positive in the right wrist. The low back was tender, with limited range of motion, as was the right knee. Right ankle range of motion was very limited, with hyperalgesia, dusky discoloration and trophic skin changes of the foot and ankle. There is foot tenderness suggesting a Morton's neuroma, and tenderness over the tarsal tunnel with a positive Tinel's. There was lateral instability if the right ankle. X-rays of the right shoulder, ankle and foot were negative except for a calcaneal spur. Diagnoses included right foot sprain/rule out plantar

fasciitis, calcaneal spur, tarsal tunnel syndrome, metatarsalgia and Morton's neuroma; right ankle sprain/rule out internal derangement, lateral instability, history of proximal medial and lateral malleolar fracture; stasis edema, right leg/rule out deep vein thrombosis; rule out reflex sympathetic dystrophy of the right foot and ankle; ongoing right wrist and hand sprain from previous injury with new carpal tunnel syndrome from crutch use; symptoms of anxiety and depression; insomnia; weight gain; NSAID-related gastritis; and cephalgia. The plan included requests for authorization of EMG/NCV of the right lower extremity to rule out tarsal tunnel syndrome, of an open MR arthrogram of the right ankle for improved evaluation of joint abnormalities, of a CT scan of the right foot and ankle to rule out fracture, and a psychological evaluation. A doctor's first report of the same date by the same orthopedist includes plans for physiotherapy 2-3x6, internal medicine evaluation, TENS unit, right wrist brace, Cam Walker, and bone scan of the whole body in addition to the requests above. These requests were reviewed in UR on 12/12/13. The right lower extremity EMG/NCV and TENS trial were approved. The bone scan, psychiatric evaluation, internal medicine evaluation, right wrist brace were deemed non-compensable and not addressed. The MR arthrogram was denied on the basis that there was insufficient documentation about why an arthrogram was needed to clarify the previous MRI results. The CT scan was denied on the basis that there is no clinical indication of a possible foot fracture with citation of ODG and ACR Appropriateness criteria. The physical therapy was denied on the basis that the patient had already had extensive physical therapy without improvement, with citation of MTUS Physical Medicine guidelines. The Cam Walker was denied on the basis that the patient presented wearing one already and did not need another. This patient has not worked since 3/24/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Arthrogram Right Ankle: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ankle and Foot chapter, MRI and MR arthrogram

Decision rationale: The clinical documentation in this case supports the performance of an MR arthrogram of this patient's right ankle. Although she had a previous MRI of the ankle which showed a posterior malleolar fracture and no osteochondral defect on 4/5/13, she continues to have significant pain and is unable to bear weight on the right foot 10 months after her injury. Though his documentation is poor, the provider has raised concerns about tarsal tunnel syndrome and Morton's neuroma. The patient clearly has chronic foot and ankle pain of uncertain etiology, and normal plain films. The provider has documented lateral instability of the ankle, which makes MR arthrogram the study of choice for the ankle. According to the evidence-based citations above and the clinical documentation provided for my review, an MR arthrogram of the right ankle IS medically necessary, because the patient has chronic ankle pain with concern for

several of the conditions for which an MRI would be recommended, and because she also has ankle instability which would warrant the performance of an MR arthrogram.

CT Scan Right Foot And Ankle: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Radiology Appropriateness Criteria, Musculoskeletal section, Chronic ankle pain and Chronic foot pain

Decision rationale: According to the ACR ankle citation above, when chronic ankle pain is of unclear etiology, normal ankle radiographs can be followed by other imaging tests, primarily directed by clinical findings. If the patient has a focal soft-tissue abnormality, both US and MRI can be considered. Peripheral nerve-related symptoms can be evaluated with US or MRI; however, US has the benefit of higher resolution. If symptoms are believed to originate from osseous structures, MRI can be considered as well as CT if there is concern for fracture. CT has been shown to be superior to radiography for fracture detection. MRI is effective in detecting osseous stress injuries. Overall, MRI is the imaging test that globally evaluates all anatomic structures, including bone marrow. US with dynamic evaluation should be considered when symptoms are only present during specific movements or positions. The ACR foot citation states that foot MRI is preferable to CT for evaluation of chronic foot pain with negative plain x-rays and concern for plantar fasciitis, tarsal tunnel syndrome, Morton's neuroma, tendinopathy, or even concern for occult fracture of the navicular. The clinical documentation in this case does not support the performance of right foot and ankle CT scans. This patient is already known to have a non-displaced fracture of the posterior malleolus noted on her previous MRI. There is no description of any incident or any clinical findings that make the presence of a second fracture likely. There are multiple documented findings and concerns that would make the performance of an MRI of both the ankle and foot preferable to CT. Based on the evidence-based citations above and on the clinical documentation provided for my review, CT scans of the right foot and ankle are not medically necessary. They are not medically necessary because the provider has not documented any history or findings that would raise concern about a new fracture in addition to the one already documented by MRI; and because he has documented concerns about several conditions for which MRI is a more appropriate study than CT.

Additional Physical Therapy 2-3 Times per Week for 6 Weeks for Right Ankle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, Physical Medicine Page(s): 9, 98-99.

Decision rationale: According to the first citation above, all therapies are focused on the goal of functional restoration rather than merely the elimination of pain, and assessment of treatment

efficacy is accomplished by reporting functional improvement. The second citation states that passive therapy is for early phase of treatment. Active therapy recommended over passive care, with transition to home therapy. Recommended quantities: Myalgia and myositis, 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, 8-10 visits over 4 weeks; Reflex sympathetic dystrophy (CRPS), 24 visits over 16 weeks. The clinical documentation in this case does not support the provision of additional physical therapy to this patient. There is clear documentation that she has already had at least 20 PT sessions, and probably more. These sessions did not result in any functional recovery. She has not returned to work in any capacity. Even if she were to be definitively diagnosed as having reflex sympathetic dystrophy, it is clear that she is unlikely to respond to any further physical therapy. Based on the MTUS citations above and on the clinical documentation provided for my review, physical therapy 2-3 times per week for 6 weeks is not medically necessary because the patient demonstrated no functional recovery due to the extensive physical therapy that she has already had, and further PT is unlikely to be helpful.

Cam Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ankle and Foot chapter, Cam Walker, and Cast

Decision rationale: The ODG references cited above state that a Cam Walker is a brand-name removable cast. Casts are not recommended in the absence of a clearly unstable joint or a severe ankle sprain. Functional treatment appears to be the favorable strategy for treating acute ankle sprains when compared with immobilization. Partial weight bearing as tolerated is recommended. However, for patients with a clearly unstable joint, immobilization may be necessary for 4 to 6 weeks, with active and/or passive therapy to achieve optimal function. The clinical documentation does not support the provision of a cam walker to this patient. She has already been immobilized in a cast for 6 weeks with no improvement in function. Prior to the placement of the cast, she is documented as walking without assistive devices. At the first visit with her new provider after casting, she is documented as wearing a Cam Walker and using crutches. Her ankle range of motion is extremely limited. It appears likely that immobilization may have actually harmed the patient. Having her begin weight bearing and ankle movement as tolerated would be more likely to produce positive results than continued immobilization. Based on the evidence-based citation above and on the clinical findings provided for my review, a Cam Walker is not medically necessary because continued immobilization of the ankle is more likely to harm than to help this patient.