

<b>Case Number:</b>	CM14-0193734		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	09/23/2013
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	11/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2014

### 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 Internal 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:

The patient is an injured worker with a history of left foot and ankle injury. Date of injury was 09-23-2013. The primary treating physician's progress report dated 10/14/2014 documented a history of fall with left foot and ankle and heel comminuted fracture with infected hardware. He has deep bony pain about the left foot and ankle with increasing pain with long standing and walking. He hurts after physical therapy, as well as long walking. He uses Percocet for the physical therapy sessions. He describes his pain level as between 4-9/10, and he gets worse with physical therapy and extended walking. He improves with medications. Physical therapy is in progress. Objective findings were documented. He has slight tenderness about the left foot ankle. He has some tenderness about the ankle. Surgical incisions are healing. This is a suggestion of granulation. Distal touch and capillary refill is intact. Diagnosis was left ankle foot comminuted fracture with reconstruction and infected hardware. The patient has right knee and low back pain from limping. The progress report dated 10/27/14 documented subjective complaints. The patient presented for a follow-up examination. He had an air cast. He was going to physical therapy. He would like to get out of the cam walker, but still has progressive soreness when he walks without it and has too much pain when walking in the ankle foot orthosis, thus he is back to wearing his cam walker. Objective findings were documented. Patient appears well developed, well-nourished and with good attention to hygiene and body habitus. Examination of the left foot reveals incision sites well aligned and coapted, no probing, no drainage, ulcers closed. Posterior tibial and dorsalis pedis pulses two out of four bilaterally. Capillary fill time is within normal limits. Minimal edema was in the left foot. There is left ankle dorsal stiffness with 15 degrees of smooth left ankle range of motion. Antalgic gait when walking barefoot with pain centered over the subtalar joint with tenderness at the anteromedial and anterolateral ankle gutter. Gait and station examination reveals abnormal pronation through midstance and toe off of the gait

cycle with moderate calcaneal aversion on neutral calcaneal stance position. X rays of the left foot were reviewed, revealing pes planus, rearfoot joint space narrowing. Diagnoses were degenerative joint disease foot, abnormal gait, ankle synovitis, and edema. Regarding the treatment plan, the patient was advised to continue physical therapy, air cast, ankle foot orthosis, and orthotics. The qualified medical examiner suggested a left rearfoot fusion. Pneumatic cam walker was dispensed. Percocet 10/325 mg one tablet every 8-12 hours as needed for pain quantity #75 was requested. A left rearfoot CT computed tomography scan was requested. X-rays of the left foot and left ankle were performed on 10/28/14. The bones are demineralized. Hindfoot fixation hardware is present. There appears be a break in one of the metallic screws. No acute bony abnormalities were noted. Overall ankle and foot alignment is maintained. No suspicious bony lesions. Soft tissues are intact. Postoperative changes with a break in one of the screws were noted. No acute bony abnormalities were noted.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **One Left Foot CT Scan: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (Colorado, 2001) (ACR ankle, 2002) See also ACR (American College of Radiology) Appropriateness Criteria

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 372-375. Decision based on Non-MTUS Citation The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 8 Neck and Upper Back Complaints, Chapter 14 Ankle and Foot Complaints, page 372-375 and on the Non-MTUS ACOEM 3rd Edition. Bibliographic Source: Ankle and foot disorders. In: Hegmann KT, editor(s); Occupational Medicine Practice Guidelines; Evaluation and management of common health problems and functional recovery in workers. 3rd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 1-268; Table 1: Summary of Recommendations for Diagnostic and Other Testing for Ankle and Foot Disorders. <http://www.guideline.gov/content.aspx?id=36625>.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses CT computed tomography of the foot. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 14 Ankle and Foot Complaints (Page 374) states that 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. ACOEM 3rd Edition indicates that CT computed tomography is recommended for investigation of forefoot and midfoot fractures. The primary treating physician's progress report dated 10/14/2014 documented a history of left and ankle foot comminuted fracture with reconstruction and infected hardware. The progress report dated 10/27/14 documented that the QME qualified medical examiner suggested a left rearfoot fusion. X-rays of the left foot and left ankle were performed on 10/28/14. The bones are demineralized. Hindfoot fixation hardware is present. There appears be a break in one of the metallic screws. Postoperative changes with a break in one of the screws were noted. Medical records document a history fracture and continued limitations of activity and pain. X-rays dated 10/28/14 demonstrated a break in the hardware. Per ACOEM 2nd

Edition, imaging may be indicated to clarify the diagnosis and assist reconditioning. Per ACOEM 3rd Edition, CT computed tomography is recommended for investigation of forefoot and midfoot fractures. Therefore, the request for left foot CT computed tomography is supported by MTUS and ACOEM guidelines. Therefore, the request for One Left Foot CT Scan is medically necessary.

**One Prescription of Percocet 10/325mg #75: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Ankle and Foot (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone/Acetaminophen (Percocet) Page(s): 74-96; 92.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. "Do not attempt to lower the dose if it is working." Supplemental doses of breakthrough medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically. Percocet should be administered every 4 to 6 hours as needed for pain. For more severe pain the dose (based on Oxycodone) is 10-30mg every 4 to 6 hours prn pain. Medical records document objective evidence of pathology on physical examination and imaging studies. Subjective complaints of pain were documented. Analgesia was documented with opioid medications. Pain was improved with opioid medications. Activities of daily living were addressed. The patient has regular clinic visits for reassessment. The medical records and MTUS guidelines support the Percocet 10/325 mg prescription. Therefore, the request for One Prescription of Percocet 10/325mg, #75 is medically necessary.