Case Number:	CM15-0212084		
Date Assigned:	10/30/2015	**Date of Injury:**	08/20/2014
Decision Date:	12/14/2015	**UR Denial Date:**	10/19/2015
Priority:	Standard	**Application Received:**	10/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Illinois, California, Texas
Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 34-year-old male who sustained an industrial injury on 8/20/14. Injury occurred when he stepped off a scaffold onto his right foot and his foot rolled in. He subsequently underwent right ankle arthroscopic debridement with drilling of a small traumatic osteochondral lesion on 4/3/15. Records indicated that 20 post-op physical therapy visits had been approved. The 10/8/15 treating physician report cited residual grade 4/10 right ankle pain and stiffness. He denied numbness, tingling, catching or giving way of the ankle. He had been wearing work boots. Physical exam documented significant limitation in dorsiflexion, about 5-10 degrees with the knee bent. When he put his foot flat on the ground, he could not bring his knee over the tip of his toe without his heel coming up. Peroneal and posterior tibial strength were 5/5. Inversion and eversion were tested with minimal discomfort. There is normal sensation to the light touch in all distributions, and no palpable effusion or tenderness. X-rays showed the ankle joint to be intact with no obvious osteochondral defect on the talar dome. The joint space was symmetric with no evidence of arthritic change. There was some calcification in the neck of the talus noted on the lateral view. He had completed 20 visits of physical therapy with residual dorsiflexion stiffness. A corticosteroid injection was recommended with additional physical therapy so that he could push the physical therapy hard and stress the joint better. He had returned to work with progressive full duty. Authorization was requested for 8 additional post-operative physical therapy visits and an intra-articular injection of the right ankle with Lidocaine, Marcaine, and 40 mg of Depo-Medrol. The 10/19/15 utilization review non-certified the request for 8 additional post-op physical therapy sessions as the injured worker had completed visits in

excess of guideline recommendation and had apparently reached a plateau with supervised therapy with no apparent benefit over a home exercise program. The request for an intra-articular right ankle corticosteroid injection was non-certified as intra-articular corticosteroid injections are not recommended for ankle/foot conditions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Operative Physical Therapy to the Right Ankle - 8 Visits: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine, and Postsurgical Treatment 2009, Section(s): Ankle & Foot.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Ankle & Foot.

Decision rationale: The California Post-Surgical Treatment Guidelines for surgical treatment of ankle sprain suggest a general course of 34 post-operative physical medicine visits over 16 weeks, during the 6-month post-surgical treatment period. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical period. Guideline criteria have been essentially met. This injured worker underwent right ankle surgery for an inversion sprain of the right ankle. He has completed 20 post-op physical therapy visits with functional improvement allowing return to progressive work. He has residual pain and significant dorsiflexion stiffness. Additional physical therapy within the recommended general course seems warranted to maximize range of motion and continue work progression. Therefore, this request is medically necessary.

Intra-Articular Injection of the Right Ankle with Lidocaine, Marcaine and 40mg of Depo-Medrol: Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Ankle and Foot Chapter (Online Version), Injections (corticosteroid).

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot: Injections (corticosteroid).

Decision rationale: The California MTUS guidelines do not provide recommendations for intra-articular corticosteroid injections. Corticosteroid injections are recommended as an option for the treatment of Morton's neuroma, plantar fasciitis, or heel spurs. The Official Disability Guidelines state that intra-articular corticosteroids are not recommended. Guidelines stat that most evidence

for the efficacy of intra-articular corticosteroids is confined to the knee, with few studies considering the joints of the foot and ankle. No independent clinical factors were identified that could predict a better post injection response. There is no compelling rationale presented to support the medical necessity of an intra-articular corticosteroid injection to the right ankle as an exception to guidelines. Therefore, this request is not medically necessary.