

<b>Case Number:</b>	CM15-0058931		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	10/04/2011
<b>Decision Date:</b>	05/18/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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: Minnesota, Florida  
 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 30-year-old female sustained an industrial injury to the left ankle on 10/4/11. The injured worker was diagnosed with a left distal fibula chip fracture. Previous treatment included x-rays, left ankle arthroscopy with chondroplasty of the talar dome, splinting, initial cast, physical therapy and medications. In an orthopedic consultation dated 3/3/15, the injured worker complained of back pain due to altered gait, bilateral hip pain, left ankle swelling and a sense of instability to the left ankle. There is a history of prior right hip surgery with associated weakness. There is also a history of congenital ligamentous laxity documented. A sibling has Ehlers-Danlos syndrome. Physical exam was remarkable for ambulation with a non-antalgic gait. There was tenderness to palpation over the anterolateral ankle with minimal swelling, full range of motion and laxity with anterior drawer on the left compared to the right. X-rays showed no degenerative changes. Prior stress films of both ankles were negative to inversion stress on 7/21/2014 current diagnoses included left distal fibula chip fracture, ankle instability and mild cavus deformity. The treatment plan included ankle ligament reconstruction with modified Brostrom repair. The request for surgery was non-certified by utilization review citing ODG guidelines

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left ankle ligament reconstructive surgery:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ankle & Foot (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 377. Decision based on Non-MTUS Citation ODG: Section: ankle and Foot.

**Decision rationale:** California MTUS guidelines indicate reconstruction of lateral ankle ligaments for symptomatic patients with ankle laxity demonstrated on physical examination and positive stress films. ODG guidelines indicate lateral ligament ankle reconstruction in the presence of positive stress x-rays identifying motion at ankle or subtalar joint. At least 15 lateral opening at the ankle joint or demonstrable subtalar movement and negative to minimal arthritic changes in the joint on x-ray should be present. Guidelines also necessitate evidence of conservative care plus subjective clinical findings of chronic instability, complaint of swelling, and objective clinical findings of positive anterior drawer, and/or osteochondral fragment, and/or medial incompetence. The documentation provided does not indicate exhaustion of nonoperative measures such as physical therapy with failure of exercise programs to increase range of motion and strength of the musculature around the ankle and foot and continuing symptoms despite physical therapy. The available documentation indicates stress films of both ankles were obtained on July 21, 2014. There is a handwritten report from [REDACTED]. Radiological report dated 7/21/14 indicating two stress views of the left ankle and two stress views of the right ankle were obtained. The impression was "no widening of ankle mortise on inversion stress views, bilateral ankles." No other stress films have been submitted in the medical records provided. In light of the negative stress films the guideline requirement of 15 lateral opening at the ankle joint or demonstrable subtalar movement has not been documented. As such, the request for lateral reconstruction of the ankle is not supported and the medical necessity of the request has not been substantiated.