

Case Number:	CM14-0096175		
Date Assigned:	07/28/2014	Date of Injury:	05/22/2013
Decision Date:	09/16/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	06/24/2014

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:

Reports reviewed note that there was a fracture to the calcaneus. The service that was modified or denied was the CT of the right foot. The request for independent medical review was signed on June 23, 2014. Per the records provided, the patient was described as a 59-year-old male injured on May 22, 2013 in a fall from a ladder. The patient had posttraumatic subtalar degenerative joint disease after a calcaneal fracture. A CT scan from August 28, 2013 showed interval healing of the calcaneal fracture with mild deformity. There was likely a stress fracture at the posterior aspect of the calcaneus, and severe bony osteoporotic change. An MRI of the right ankle from January 7, 2014 showed some deformity of the calcaneus due to a previous calcaneal fracture as seen at the time of the previous CT scan and a partial tear or tendinopathy of the distal 3-4 cm of the Achilles tendon. On March 17, 2014 the patient had complaints of right heel pain. There was pain with compression of the calcaneus. On May 9, 2014 the patient had pain in the right ankle. The patient was noncompliant with treatment. There was moderate swelling, pain with medial and lateral compression and the inability to dorsiflex. They continued with crutches and a CT scan. On May 22, 2014 the patient continued with complaints of pain in the right ankle. There was slight swelling and pain along the medial and lateral area and the sinus tarsi. The plan was for a CT scan and the use of assistive devices. There is no documentation of a significant change in symptoms since the previous CT scan. There was a note from July 16, 2014 that noted they attempted to get a repeat CT scan to evaluate the posterior facet. An MRI was done several months after the injury demonstrating collapse and impingement of the sinus tarsi secondary to the collapse of the calcaneal fracture. The patient did not report any ankle anterior irritation or impingement symptoms. The pain is mainly along the posteromedial and lateral aspect in the areas overlying the subtalar joint. The right foot demonstrates continued irritation along the medial and lateral aspect of the sinus tarsi and the subtalar joint.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of right foot: 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 Chapter.

Decision rationale: The ODG Guidelines note that ankle CT provides excellent visualization of bone and is used to further evaluate bony masses and suspected fractures not clearly identified on radiographic window evaluation. However, in this case, the patient has had prior advanced imaging studies, without clinical, subjective, or objective evidence of worsening since the last study to warrant a repeat imaging study. As such, the request is not medically necessary.