Case Number:	CM15-0010079		
Date Assigned:	01/27/2015	Date of Injury:	10/03/2012
Decision Date:	03/17/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/16/2015

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: Ohio, North Carolina, Virginia
Certification(s)/Specialty: Family Practice

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 injured worker is a 59 year old male who sustained a work related injury October 3, 2012. Past history included gouty arthritis, a metatarsal stress fracture treated for 6 weeks in a moon boot March 2011 and an open reduction internal fixation tarsometatarsal dislocation and platelet rich plasma injection May 2012. After return to work, he was going up stairs and felt the foot pop and collapse and was later diagnosed with non-union second metatarsal base and a bone stimulator was recommended. A second surgery was performed March 17, 2013, tarsometatarsal fusion of the first second and third metatarsals as well as gastrocnemius release and an open reduction internal fixation of the non-union of the second metatarsal. According to a treating physician's report, dated December 11, 2014, the injured worker presented as a follow-up with left foot pain with decreased mobility. He stated the symptoms have been chronic traumatic and occur constantly and unchanged. Diagnosis is documented as ankle instability (previously diagnosed as calcaneofibular (ligament) ankle sprain). Treatment plan included a request for authorization of bilateral Arizona braces to avoid tripping and falling, also gave a shoe list for appropriate shoe type for correction.According to utilization review dated December 23, 2014, the request for purchase of Arizona Brace, bilateral feet QTY: 2 are non-certified, citing MTUS ACOEM Guidelines Ankle and Foot Complaints and (ODG) Official Disability Guidelines Ankle & Foot (updated 12/22/2014) Arizona Brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Arizona Brace, Bilateral feet, quantity 2: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot, Arizona Brace

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ankle and foot

Decision rationale: Ankle bracing is not recommended in the absence of a clearly unstable joint. 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. After Achilles tendon repair, patients splinted with a functional brace rather than a cast post-operatively tended to have a shorter in-patient stay, less time off work and a quicker return to sporting activities. There was also a lower complication rate (excluding rerupture) in the functional brace group. In a randomized, controlled trial of a removable brace versus casting in younger patients with low-risk ankle fractures, treatment with a removable ankle brace was superior to treatment with a cast. According to this systematic review of treatment for ankle sprains, for mild-to-moderate ankle sprains, functional treatment options (which can consist of elastic bandaging, soft casting, taping or orthoses with associated coordination training) were found to be statistically better than immobilization for multiple outcome measures. It is recommended to use a brace or a tape to prevent a relapse after ankle sprain, but also to phase out the use of brace or tape in time. The use of tape or a brace reduces the risk of recurrent inversion injuries, but is unclear whether a brace is more effective than a tape. The preference for the choice of a brace or a tape depends on the individual situation, but due to considerations about practical usability and evaluation of costs, a brace is initially preferable to tape.In this instance, clear ankle instability is demonstrated bilaterally as evidenced by laxity in terms of talar tilt, subtalar tilt, and anterior drawer testing. Purchease of bilateral Arizona braces are therefore medically necessary.