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Notice of Independent Review Decision

Case No.: 30849
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DATE OF REVIEW: 11/19/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: CT R Foot 73700

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas Board Certified Orthopedic Surgeon
Texas Board Certified Orthopedic Sports Medicine

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 08/12/10 - Clinical Note - MD
2. 08/24/10 - Utilization Review
3. 09/14/10 - Utilization Review
4. 09/20/10 - Clinical Note - MD
5. 10/04/10 - Clinical Note - MD
6. 10/20/10 - Clinical Note - MD
7. 10/29/10 - Clinical Note - MD
8. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury on xx/xx/xx when a box of olive oil fell onto the outside of her right ankle.

The employee saw Dr. on 08/12/10 with complaints of diffuse pain extending from the calf to the right mid foot. The employee had been wearing canvas ankle bracing and had been on weight bearing on crutches. Current medications included Nabumetone, Tramadol, and Hydrocodone. Physical examination revealed mild to moderate swelling of the right foot with slight ecchymosis. There was no obvious deformity. There was diffuse tenderness from the right calf to the right mid foot. There

was no significant right calf swelling. There was no evidence of neurovascular compromise in the right lower extremity. Radiographs of the right foot and ankle were noted to be unremarkable. The employee was assessed with subacute right mid foot contusion. The employee was recommended for a CT of the right foot. The employee was placed in a 3-D brace.

The request for CT of the right foot was denied by utilization review on 08/24/10. The mechanism of injury was not entirely clear. There was no evidence that a course of conservative treatment had been completed or attempted and failed, or that there was a potentially serious internal derangement.

The request for CT of the right foot was denied by utilization review on 09/14/10. The initial physical examination findings were consistent with a mild contusion of the foot. The exact mechanism of injury had not been documented. The employee reported 30% improvement in symptoms while wearing a brace. There was no indication of any pathology other than a mild soft tissue contusion. There was no conventional radiographic or clinical evidence of osseous injury or any other pathology present that would require additional imaging with a CT scan.

The employee was seen for follow up on 09/20/10. The employee reported 20% improvement in her symptoms. Physical examination revealed diffuse mild to moderate swelling of the right foot. The employee was recommended for CT of the right foot.

The employee was seen for follow up on 10/04/10. The employee complained of right mid and plantar foot pain. Physical examination revealed a mid foot circumference of 34cm on the right and 33cm on the left. The note stated the employee was unable to full bear weight on the right foot. The employee's medications were refilled.

The employee saw Dr. on 10/20/10 with continued complaints of diffuse right foot pain. The employee was able to full bear weight on the right lower extremity, but she ambulated with a moderately antalgic gait. The employee had been wearing the 3-D brace and using the crutches when ambulating. Physical examination revealed diffuse swelling, redness, and superficial tenderness to touch of the right foot. Radiographs demonstrated punctate osteoporosis, consistent with non-weight bearing and possible development of reflex sympathetic dystrophy.

The employee saw Dr. on 10/29/10 with complaints of right foot pain. The employee rated the pain at 8 to 10 out of 10. The pain radiated to the ankle and calf. The

employee had tried self-massage. The employee reported change of color of the foot and swelling. She stated the distal foot was reddish in color, while the proximal foot was purple. Physical examination revealed a purplish mottling discoloration of the foot. Swelling of the right ankle and foot was noted. There was minimal movement of the right ankle or toes due to pain. The employee complained of calf pain with knee extension. There was tenderness to pressure over the calf muscles. An attempt to check the right Achilles reflex caused severe pain. The employee was assessed with reflex sympathetic dystrophy of the lower limb. The employee was prescribed Hydrocodone 7.5/325mg. The employee was recommended for a lumbar sympathetic block to rule out sympathetically maintained pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The employee sustained an injury to the right ankle consistent with a contusion injury. The employee's initial radiographs of the right ankle were unremarkable to with no suspicions of any fractures. Guidelines recommend the use of CT evaluation for the ankle and foot to address fractures that are not well defined on radiograph studies. Given that the initial radiograph studies did not demonstrate any evidence of fractures in the right ankle, and the employee's current complaints are more related to causalgia; a CT study at this point in time would not reasonably guide the employee's course of treatment and is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

Official Disability Guidelines, Online Version, Ankle and Foot Chapter.