

Matutech, Inc
881 Rock Street
New Braunfels, TX 78130
Phone: 800-929-9078
Fax: 800-570-9544

Notice of Independent Review Decision

Date: March 25, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI ankle and MRI foot without contrast

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

Diplomate American Board of Orthopaedic Surgery
Fellowship Trained in Foot and Ankle Disorders

REVIEW OUTCOME:

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

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI

- Utilization Reviews (01/30/13, 02/22/13)

- Office visits (05/17/12 - 11/19/12)
- Letter (01/22/13, 02/17/13)
- Reviews (01/30/13, 02/22/13)

- Office visits (02/23/11 - 03/18/13)
- Letters (02/24/12, 03/11/13)
- Diagnostics (05/15/12)

ODG criteria have been utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a female who on xxxxxx, missed the landing on a spiral staircase while at work and injured her left ankle.

On xxxxxx, evaluated the patient for left calcaneal fracture. noted the patient was seen in, where an extra-articular fracture of the calcaneus was diagnosed. Both x-rays and computerized tomography (CT) scan were performed. placed the patient in a compressive wrap. The patient had pain and swelling in her left foot and ankle. She stated the pain was sharp, stabbing, burning, throbbing and constant in nature. She had associated swelling and ecchymosis. Her pain level was 7 to 8/10. The problems listed were displacement of cervical intervertebral disc without myelopathy and displacement of thoracic and lumbar intervertebral disc without myelopathy (onset December 6, 2006). Examination of the left lower extremity showed a large amount of ecchymosis, mainly over the lateral aspect of her left foot and also over the arch of the left foot. Most of the swelling was about the lateral aspect of her left foot and ankle. reviewed the x-rays (ER) which showed a fracture of the calcaneus beginning posterior to the posterior facet and extending into the neck of the calcaneus. CT scan showed a fracture line going into the middle facet of the subtalar joint, but no displacement of the fracture. assessed nondisplaced left calcaneal fracture mainly extra-articular and nondisplaced fracture into the middle facet subtalar joint. He opined that there was no need for surgical intervention. The patient was placed in a Robert Jones dressing. recommended non-operative treatment, rest, ice, compression and elevation (RICE), and doing leg lifts, knee range of motion (ROM) and flexion-extension exercise of her toes to diminish her chances of deep vein thrombosis. When her pain and swelling diminished, she would be placed in a compressive stocking, a fracture boot and motion exercises. The patient was not allowed to weightbear until the fracture was healed.

On xxxxxx, evaluated the patient for complaints on the lateral aspect of her ankle. The patient was concerned that the cast might be too tight. The patient was in a Robert Jones compressive dressing and cast. On examination, she had less swelling of the foot. Diagnosis was closed fracture of calcaneus. The patient was placed in a short leg with toe plate cast and was allowed to decrease the amount of time she had her foot elevated.

On xxxxxx, evaluated the patient for left ankle and foot pain that was aching, severe, constant and worsening. Previously the patient underwent x-rays that confirmed a nondisplaced comminuted calcaneus fracture. Magnetic resonance imaging (MRI) performed on August 11, 2011, showed that the anterior talofibular ligament (ATFL) was chronically disrupted mild marrow edema in the calcaneus. Computerized tomography (CT) scan dated February 22, 2011, confirmed a minimally displaced comminuted calcaneus fracture. Recently performed electromyography (EMG) showed sensory changes but no motor changes. The patient had not returned to work since her injury. She was seen who placed her in three separate casts, the conservative treatment for the calcaneus apparently producing union of the calcaneus. Unfortunately, the patient continued to have severe pain with activity with weightbearing. She was unable to tolerate standing

on bare feet. She had some decreased sensation at the anterior lateral distal leg. She had pain over the Achilles, the lateral ankle including the peroneal tendons and ATFL. She also had pain across her plantar foot. Medical history was positive for osteoporosis. The patient had a limping gait and she ambulated with a walker. Examination of the left foot/ankle showed tenderness of the lateral side, the gutter ankle, the calcaneal tuberosity and the Achilles tendon insertion. There was tenderness of the Achilles tendon, the sinus tarsi and the peroneal retinaculum. Muscle strength on the left side was 3/5 for peroneus brevis and longus, extensor digitorum longus and brevis at 4/5, extensor hallucis longus (EHL) 4/5 and tibialis anterior 4/5, posterior tibialis 4/5 and gastrocnemius 4/5. Neurological examination showed tactile dysesthesia/hyperesthesia in the distal extremities. X-ray of the left ankle was unremarkable. diagnosed reflex sympathetic dystrophy (RSD) of the lower limb and sprains and strains of the ankle. He recommended consulting a pain management specialist and the possibility of having a sympathetic block. If the patient failed to improve with the sympathetic block, a second approach would be to use selective injections most likely to the sinus tarsi within the subtalar joint and the peroneal retinaculum. The patient was prescribed Norco.

On xxxxxx, evaluated the patient for ongoing complaints of left calcaneus fracture, RSD, lumbar strain, cervical strain and left ankle ligament tear. The patient continued to feel increasing pressure and pain in her heel. Overall, she had been using the cane more and had not been using the walker. She reported her other injuries were stable. She was also having difficulty with the insurance company to cover the RSD. The referral a couple of weeks ago had been denied as was not in the network. Examination of the left foot showed tenderness to the palpation of the calcaneus and a jerking sensation with palpation. diagnosed left calcaneus fracture, RSD, left ankle ligament tear, lumbar strain and cervical strain. He continued medications and referred the patient to and. The patient was placed on modified duty.

On xxxxxx, the patient reported that over the last few weeks, she had been using the cane less and therefore she had been experiencing increased pain in her left foot. She also reported having increased pain in her left hip and right posterior knee regions. was awaiting follow-up evaluation. The patient's designated doctor evaluation (DDE) was pending. would send a letter to the adjuster explaining the importance of follow-up evaluation by. He continued modified duty.

Per a letter dated February 24, 2012, reported that the patient continued to have moderate-to-severe left heel pain since her initial evaluation that did not appear to be improving with conservative treatment. The patient would like to consider more aggressive treatment options. She had seen in the past and she did not want to perform any treatment on the ankle ligament tear until her RSD was treated and was possibly controlled.

On xxxxxx, noted that a couple of weeks ago the patient had been re-evaluated of pain management. had recommended an invasive treatment of the ankle if needed. He did not feel that any other treatment was needed for the RSD.

Overall, the patient continued to feel some slight improvement. She reported some decrease in sensitivity of the left heel. She reported sensitivity was presently more located in the lateral ankle region. She also reported overall improvement in her right knee pain and left lower back pain. She continued to have some left upper back pain but that seemed to be stable from the last visit. Her DDE was still pending. Examination of the left foot showed mild tenderness to palpation of the calcaneus that seemed to be improved since the last visit. continued modified duty and referred the patient to an orthopedic foot and ankle specialist.

On xxxxx, the patient reported that she continued to have left heel pain that seemed to be worse with ambulation. She still was using the cane to ambulate since her last visit. Examination of the left ankle showed tenderness to palpation over the anterior talofibular ligament. Examination of the left foot showed tenderness to palpation of the calcaneus with a slight jerking response to palpation. referred the patient to an orthopedic foot and ankle specialist.

On xxxxx, the patient was seen in a follow-up for her left calcaneal fracture, RSD and left ankle ligament tear. The patient reported having a designated doctor's evaluation approximately 10 days prior. She complained of ongoing pain in the left ankle and heel region. She tried not to use the cane at home and did feel some increased pain and increased back and neck pain without using the cane. She also felt some instability to the ankle and pain worsening throughout the day. The patient had not yet received the designated doctor's evaluation and had not heard about the referral to see, an orthopedic foot and ankle specialist. assessed left calcaneus fracture, RSD and left ankle ligament injury and was awaiting report from designated doctor. He recommended follow-up in one month.

On xxxxx, noted pain and stiffness in the left foot. The patient saw. The fracture went on to heal, but the patient had severe pain, therefore, consultation with was arranged. The patient had pain severe to the point where she was not able to return to work. The pain was described as pressure and burning, localized to the heel and ankle area. She had pain that occurred several times daily and was associated with giving way of her ankle. On exam, she had swelling of the left foot, marked decreased motion of her subtalar joint and pain reproduced on attempted motion. She had pain and swelling in the area of her sinus tarsi. The left subtalar joint was injected with 1% lidocaine which stopped her pain. She still had varus present of her left calcaneus. X-rays of the left ankle showed well-aligned mortise. The posterior portion of the posterior facet had bone on bone changes between the posterior talus and the calcaneus. A slight step-off of the calcaneus was seen just posterior to the posterior facet which was probably consistent with her history of a nondisplaced calcaneal fracture. assessed posttraumatic arthritis of left subtalar joint, history of a nondisplaced fracture of her left calcaneus treated non-operatively. He recommended CT scan of the left subtalar joint. If it confirmed posttraumatic arthritis then a surgical recommendation would be made.

On xxxxx, noted the patient had seen and had undergone injection in her left ankle. The patient reported having some increased "pressure" after the injection. According to the patient, wanted to perform a computerized tomography (CT) given that there were some signs of arthritis on the x-ray that was taken the previous day. Based on the CT, wanted to determine the future treatment recommendations. The patient reported that she was scheduled for a designated doctor's visit the next week to determine if she was at MMI. She had a designated doctor's visit approximately one month ago for the extent of injury determination. The designated doctor concluded that it did not include ligament tear, however, in the doctor's opinion RSD was not a compensable diagnosis. The patient also complained of left earache that she had approximately one and half weeks ago. The patient reported that the earache was intermittent prior to that and reported not having any ear pain for the last three to four days. She was concerned about this because she was told by her primary care physician (PCP) that it could be due to trigeminal neuralgia given that the ear examination was normal. The patient was concerned due to possible correlation of trigeminal neuralgia with RSD. on examination of the left ankle noted that there was some mild lateral edema. There was hypersensitivity to touch over the lateral ankle and the lateral mid foot. The capillary refill was less than 2 seconds. The sensory was intact. opined that the patient had RSD based on the evaluations of orthopedic foot surgery and of pain management. disagreed with the designated doctor's finding that it was not a compensable injury. He recommended that the patient receive a letter from explaining the details of her RSD symptoms. diagnosed left calcaneus fracture, RSD and left ankle ligament tear. He further opined that the patient was not at MMI at that point of time and believed that she needed further care for possible repair of her ankle ligament tear given that she had a lot of feeling of laxity of the ankle. He recommended follow-up and later follow-up to his clinic after a month.

On xxxxx, magnetic resonance imaging (MRI) of the left ankle without contrast revealed: (1) Bony contusion and likely trabecular microfracture above the talar neck. No calcaneal fracture or contusion was present. (2) Remote appearing partial thickness tear of the anterior talofibular ligament. (3) Peroneus brevis degenerative tendinopathy.

On xxxxx, CT of the heel without contrast was performed in comparison to the MRI on the same day. This did not show any fracture. However, the comparison MRI from the same day demonstrated a trabecular microfracture and contusion of the talar neck, which was not well evaluated with CT imaging. (2) There was osteopenia. (3) Degenerative flattening of the peroneus brevis.

On xxxxx, MRI of the right hip revealed: (1) Mild right hip osteoarthritic changes without acute abnormality identified. (2) Mild gluteus medius and maximus degenerative tendinopathy and common hamstring degenerative tendinopathy.

On xxxx, saw the patient who continued to do poorly with moderate-to-severe, dull, aching, throbbing pain throughout her left ankle and leg, making it extremely difficult to stand, walk, function or do any activities. She required a quad cane for

ambulation. She had morning stiffness lasting throughout the day and continued to have swelling, pain, paresthesias, weakness and limitation of the left foot, ankle and leg. The patient had not improved with medications and continued to have general mild-to-moderate pain throughout her fibromyalgia points through her spine and extremities. Her current medications included hydrocodone, Soma, vitamin D, alpha-lipoic acid, apple cider vinegar, digestive enzymes, multivitamins, B-complex, aloe-vera capsules, energy greens and Noni juice. History was positive for vitamin D deficiency on supplements; hyperlipidemia under treatment; RSD left lower extremity, which had been recommended for some corrective surgery, but not yet approved. Review of systems (ROS) was positive for fatigue, easy bruising, sensitivity to sunlight, neck pain, back pain, joint pain, anxiety, insomnia, imbalance, weakness of the left ankle; paresthesias, sweating, discoloration and swelling of the left ankle. Examination revealed some mild erythema and some mild swelling of the foot and ankle with severe tenderness and pain and some moderate limitation of the left ankle. There was no swelling or limitation of the hands, wrist, elbows, shoulders, hips, knees, right ankle and right foot. There was some mild tenderness through the paraspinal muscles and extremities. On neurological examination, there was weakness of the left foot and hyperesthesias of the left foot and ankle. The patient had difficulty getting up from chair and ambulated with limp and pain favoring the left foot and ankle. She used a quad cane for ambulation. assessed fibromyalgia with mild activity, controlled long-term over the years, left lower extremity pain, paresthesias and evidence of RSD which the patient had never had in the past, except after the injury this past year. The left lower extremity pain and difficulty were strictly part of the RSD and not related at all to her fibromyalgia. Fibromyalgia did not involve the foot and ankle. It was characterized by tender points more proximal and spinal. The patient had fibromyalgia for many years without any trouble with a general ability to walk. This condition looked limiting and disabling for the patient and now was strictly related to her injury which resulted in an RSD situation. She had not improved despite maximum medical treatment and the only hope for improvement was through surgery. recommended continuing current supportive care, medications and treatment and proceeding with corrective surgery as soon as it was approved. He recommended recheck with himself in three to four months.

On xxxx noted that the patient had undergone a DDE which had found her not at MMI. The designated doctor had sent her for a CT of the left heel and MRI of the left ankle. The MRI of the left ankle showed a bony contusion and likely trabecular microfracture of the talar neck. It was apparent that the calcaneal fracture had resolved. She also had a partial thickness tear on the posterior trabecular ligament. She had not seen again. The patient continued with her pain in the left heel that she described as a pressure type of pain and had been using a pronged cane but she did walk around without the cane while at home. She continued with some neck pain that radiated to the lateral scapula and seemed to be a little worse than the last visit. She reported that her lower back pain had been doing well. On examination of the left ankle, there was no edema. There was moderate tenderness on the lateral aspect extending to the forefoot region. There was negative anterior drawer's sign and there was slight decreased dorsiflexion and plantar flexion which seemed to have improved from previous

visit. Examination of the neck showed full ROM and mild TTP in bilateral paraspinal muscles on the inferior aspect of the neck. assessed left talus fracture, left ankle ligament tear, RSD, cervical strain and healed left calcaneal fracture. He stated that given the fact that the patient was found not at MMI and the MRI findings of the talar fracture, the patient needed evaluation to find out what further treatment was needed at that point of time. He advised the patient to continue medications, modified duty and follow-up in one month.

On xxxx, reviewed the CT scan and MRI scan from May. He assessed microtrabecular fractures involving the head, neck and body of the left talus, tendinosis left peroneus brevis tendon with interstitial tearing—symptomatic and history of non-displaced fracture of the left calcaneus after fall at on xxxxxx. He prescribed Miacalcin nasal spray, recommended a right PTB ankle foot orthosis (AFO) to unweight her right foot and ordered a trilaminar orthotic on the right side to level her pelvis. He also recommended shoe wear and daily pool exercise.

On xxxx, noted the patient had persistent pain and swelling in her left foot. Miacalcin nasal spray had been denied by the carrier. X-rays were obtained which were unchanged from previous. recommended brace and opined that it was medically necessary.

On xxxxxx, noted that the patient was able to get her Miacalcin nasal spray. She did not have the AFO brace. She had undergone a designated doctor evaluation (DDE) who opined that she was not at MMI. The patient continued to have pain in her left foot. She was placed in a short leg weightbearing cast. recommended fitting the AFO brace once approved.

On xxxxx, noted the patient continued to have the same level of pain. The AFO brace had not been fabricated. Examination showed minimal to no swelling of her foot. The patient had discomfort to palpation of her ankle and hindfoot area. opined an off loader brace in an AFO design would be able to get the patient back to work. However, it had been denied by the insurance company. The patient was placed off work.

On xxxxx, noted the patient was doing poorly with moderate-to-severe, throbbing, aching pain through her left ankle and heel with poor healing. He reported that the patient had been recommended Miacalcin nasal spray, but this caused some floaters in her eyes and visual disturbance. So she had to stop it. She had not been approved for any further corrective surgery for the left ankle but would be getting another opinion. The patient required occasional small doses of hydrocodone for pain relief along with occasional Soma compound. She remained on her supplements and was undergoing eggshell therapy as well. She was extremely limited in standing and walking and being active and was becoming quite miserable. Review of systems (ROS) was positive for some visual changes, blurred vision and sensitivity to sunlight, diffuse pains in her body, some weakness, nocturia and cold intolerance. Examination showed severe tender points throughout the paracervical and parathoracic muscles and sacroiliac (SI) joints. There was some swelling, pain, tenderness, limitation of motion of the

right knee in the popliteal fossa. assessed fibromyalgia, chronic pain syndrome, RSD left lower extremity with poor healing and chronic pain and recommended considering conservative care. He stated the patient remained disabled at that point with her condition and she should make sure that she stayed on vitamin D and continued her pain control as needed. He also advised the patient to have her vitamin D levels checked to make sure how her supplement therapy was going and recommended follow-up in four months.

On xxxxx, performed a post designated doctor required medical evaluation (PDDRME). He noted the following:

The patient had a significant prior history related to this compensable injury in the form of lower back injury that resulted in lumbar disc injury at L4-L5 and cervical fusion. Surgery outside the compensable injury included having a prior cervical fusion. X-rays of the cervical spine dated March 23, 2011, revealed stable anterior fusion and discectomy from C5 through C7; stable mild canal narrowing with effacement. X-rays of the left shoulder dated March 3, 2011, revealed mild spurring of the acromioclavicular (AC) joint without acute osseous findings; surgical changes involving the left axilla and cervical spine. X-rays of the scapula dated March 3, 2011, revealed no acute osseous findings. X-rays of the pelvis dated March 3, 2011, revealed mild degenerative changes. MRI of the cervical spine dated March 3, 2011, revealed degenerative changes; small disc extrusion at L3-L4; posterior annular tear at L4-L5 without protrusion; mild canal narrowing at L3-L4; and no acute findings. Electrodiagnostic studies dated August 18, 2011, revealed superficial fibular neuropathy sensory only. Electrodiagnostic studies dated August 8, 2011, revealed right carpal tunnel syndrome (CTS). MRI of the right hip dated March 3, 2011, revealed osteoarthritic changes without acute abnormality, mild gluteus medius and minimus degenerative tendinopathy. MRI of the heel dated January 15, 2012, revealed no fracture. MRI of the left ankle dated May 15, 2012, revealed bony contusion and likely trabecular microfracture talar neck, no calcaneal fracture or contusion and partial thickness tear of the anterior talofibular ligament, and peroneus brevis degenerative tendinopathy. in the course of treatment noted that the patient was treated initially (ER) followed on xxxxxx. The patient was found to have left foot calcaneus fracture. reported in that visit that the patient's only complaint was pain and swelling in her left foot and ankle. She subsequently initiated the treatment with, followed. The diagnosis expanded to include neck and lower back pains/strains, bilateral hip contusions, shoulder pain and right knee contusion. The patient was subsequently referred to several specialists for a left ankle/foot including,. and. At that point of time, the other injured body parts were not accepted as a part of these compensable injuries nonetheless had resolved. had determined the patient had an extra-articular calcaneal fracture to the left foot with an AFTL tear. She was treated conservatively. On October 13, 2011, stated that he did "not have a firm answer as to the etiology of a pain". He recommended pain management consult. Both and diagnosed the patient with signs of RSD. concluded that the patient was a candidate for ATFL reconstruction "once her RSD was better."

opined that the patient had not reached a point of clinical MMI and therefore an impairment rating (IR) was not indicated. Once the cast was removed, the patient needed to continue conservative treatment to address her talar fractures and

peroneal tendinosis. Treatment could include physical therapy (PT) and use of an AFO brace. The compensable injury included the calcaneal fracture which had healed the AFTL rupture, the talus micro trabecular fracture and RSD which had resolved.

On xxxxxx, the patient reported that she was comfortable in the cast. Examination of the left lower extremity showed some dependent rubor and some mild swelling of the left foot. recommended wearing a fracture boot until the patient was fitted with a brace.

On xxxxx, the patient returned to for a follow-up of bracing for treatment of micro trabecular fractures involving the majority of her left talus including the left talar head, neck, body and tendinosis of her peroneus brevis tendon with interstitial tearing. He noted that the patient had problems including displacement of cervical and thoracic or lumbar intervertebral disc without myopathy since December 8, 2006; rupture of tendon, non traumatic, other tendons of foot and ankle; stress fracture of other bone and closed fracture of calcaneus. Examination revealed that the patient's AFO had been fabricated and appeared to be approximately fashioned. She still had some discomfort ambulating in the AFO and her pelvis was not level. believed that one cm lift to the sole of her right shoe would level her pelvis so as not to cause problem with her hips and back. Examination of the left lower extremity showed tenderness much as previously described over the peroneal tendons and over the head, neck and body of the talus with associated swelling present. He assessed stress fracture of other bone and rupture of tendon, non-traumatic; other tendons of foot and ankle. Micro trabecular fractures involving the majority of her left talus including the head, neck and body approximately controlled in her AFO. There was tendinosis of the peroneus brevis tendon with interstitial tearing which continued to be symptomatic and history of non-displaced fracture of the left calcaneus fracture after fall on xxxxxxx. He advised the patient to go back and see the brace maker and have him make adjustments so that her pelvis was leveled and to wear the brace for all weightbearing activities. allowed her to return to light duty work of desk job only in her AFO and recommended follow-up in three months.

On xxxxx, evaluated the patient for the left foot complaints. The patient was previously seen in November when she was suggested modifications made to the AFO. Unfortunately, over the past two weeks she had increasing pain over the lateral foot. The patient reported that the pain was worse than it had been in the past, but in the same area. She was not able to wear her brace on several occasions. She continued to have anteromedial ankle pain which was stable. Examination showed exquisite tenderness along the peroneus brevis tendon. She was mildly tender over the anteromedial talus. There was mild persistent edema. X-rays of the left ankle showed no fracture or dislocations and no interval changes from the x-rays from July of last year. Ms. assessed microtrabecular fractures involving the majority of the left talus including the head, neck and body, tendinosis peroneus brevis tendon with interstitial tearing which was persistently symptomatic, history of nondisplaced fracture left calcaneus after fall when the patient was standing on stairs xxxxx. Ms. recommended return to discuss her

surgical options. The patient was agreeable to that. The patient was to continue with the ankle foot orthosis (AFO).

On xxxxxx, evaluated the patient for continued severe pain in the lateral aspect of her left foot. The problems listed were displacement of cervical intervertebral disc without myelopathy, displacement of thoracic or lumbar intervertebral disc without myelopathy, lumbar intervertebral disc without myelopathy, rupture of tendon, nontraumatic other tendons of foot and ankle, stress fracture of other bone and closed fracture of calcaneus. noted that the patient had significant relief with physical therapy (PT). The patient reported that she had her AFO adjusted several times, but after she wore the AFO for a short period of time the lateral aspect of her left leg and foot became completely numb, but she still had pain if she tried to walk in the AFO. Examination showed an effusion in the left peroneal tendon sheath, tenderness over the peroneal tendons and tenderness diffusely between the left fourth and fifth metatarsal distally, the lateral aspect of her left fifth metatarsal head and then posteromedial left ankle. The patient had pain to percussion of her sural nerve, but not truly neuritic symptoms. It was noted from her previous MRI that she had micro-trabecular fractures involving majority of left talus including the head, neck and body and also tendinosis of her peroneus brevis tendon with some interstitial tearing. Sural nerve was blocked about 3½ inches above the tip of the lateral malleolus. Examination showed no interval change in the pain over the lateral aspect of the left foot and ankle. The patient continued to be painful to palpation of the peroneal tendons. She continued to have discomfort between the fourth and fifth metatarsals. Examination of her AFO showed what appeared to be appropriately fashioned and there was not a blurring problem in the AFO. Review of the patient's x-rays from her last visit showed no evidence of avascular necrosis, no significant arthritis. assessed tendinosis left peroneus brevis tendon with interstitial tearing–suspected progression of tendinosis, microtrabecular fractures involving the majority of the left talus including the head, neck and body and history of non-displaced fracture of the left calcaneus after fall on xxxxxx. recommended second look at the patient's peroneal tendons and also the lateral forefoot as the lidocaine injection proved that there was no involvement of her sural nerve. ordered MRI of the left peroneal tendon and foot. He opined that it was quite possible that the brace was aggravating the patient's pain. The patient was going to use her wheelchair.

On xxxxx, a preauthorization request was submitted for MRI of the left ankle and MRI of the left foot without contrast.

Per utilization review dated January 30, 2013, the request for MRI of the left ankle and left foot without contrast was denied with the following rationale: *“DOI for this IW was xxxxxxx. IW fell down stairs. IW has diagnoses of prior cervical injury, lumbar strain, hip contusion and left shoulder strain. IW has chronic foot and ankle pain that is noted especially on the lateral aspect of foot. IW is post lumbar and cervical surgery. IW has chronic pain in ankle and foot not responsive to injection, exercise and medications including narcotics. IW has had recent MRI of ankle and CT of heel - May 15, 2012. Reports note partial tearing of peroneus brevis, talar neck microtrabecular fracture and healed non-displaced calcaneus*

fracture. No surgery is planned and there has been no noted recent change in clinical presentation. Rationale for repeat imaging studies at this time without agreed plan for future surgery is unclear to me."

On xxxxxx, a request for reconsideration (appeal) of the adverse determination for MRI of the left ankle and MRI of the left foot was submitted.

On xxxxxx, the patient reported increased pain to the point that she was having difficulty standing in the shower. Examination showed exquisite tenderness to palpation along the peroneal tendons and swelling in the peroneal tendon sheath. Previously a block was placed at her sural nerve and that did not change the magnitude of her pain indicating that her pain was coming from her peroneal tendons. She had been treated in an AFO for tendinosis of the left peroneus brevis tendon with interstitial tearing. diagnosed worsening left peroneal tendon pain with effusion in the peroneal tendon sheath; suspect progression of tearing, left peroneus brevis tendon; micro-trabecular fracture involving the majority of left talus including head, neck and body and history of a non-displaced fracture of the left calcaneus after a fall on xxxxxx. He recommended MRI to look at the possibility of progression of tearing of the left peroneus brevis tendon and whether the patient needed operative intervention. The patient should stay in her AFO to protect the tendon from further damage.

Per reconsideration review dated February 22, 2013, the appeal for MRI of the left ankle and MRI of the left foot without contrast was denied by, with the following rationale: *"The initial adverse determination should be upheld. No additional medical information was provided upon which to base a recommendation that the initial level of determination should be amended or overturned. The patient has had prior imaging of the foot and ankle anatomy and pathology have previously been well defined. There is no medical rationale for repeat imaging provided. Peer to peer was not successful."*

Per letter dated March 11, 2013, the medical records establish the clinical indication and necessity for the MRI of the ankle and foot. The patient had not responded to extensive conservative care regimens. The information gleaned from this examination was unobtainable any other way.

On xxxxx, the patient returned for follow-up of pain and swelling over the lateral aspect of the left foot. noted worsening of the pain and swelling over the lateral aspect of the left foot and ankle. The patient was no better than before. She had a large effusion in her peroneal tendon sheath that extended from the lateral aspect of her foot to the posterior aspect of her ankle. Her area of maximum tenderness was over the peroneal tendons at about the level of her peroneal tubercle. She had tenderness to palpation of the tendon distally and proximally, but maximum tenderness near the tubercle. recommended reconsidering the MRI of the left foot to make a surgical decision. If there was worsening of her peroneus brevis tendon pathology, then surgery would be recommended.

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

Records for review: The records that were forwarded for review begin with the evaluation by on xxxxxx, noting that the patient had been seen previously at the emergency room and had a CT scan showing extra-articular fracture of the calcaneus. She also had x-rays obtained. She was placed into a compressive wrap. The pain levels of 7 to 8 on a 10 scale were reported with also noted swelling and ecchymosis.

noted on review that the CT scan showed a nondisplaced left calcaneal fracture primarily extra-articular and nondisplaced fracture into the middle facet of the subtalar joint. He stated there was no need for surgical intervention but placed the patient into a compressive dressing. She was to do leg lift and range of motion exercises as well of the knee and toes.

The patient was re-assessed on xxxxxx. He noted decreased swelling of the foot. The patient was placed into a short leg cast with toe plate.

The patient had an assessment on xxxxx, noting that there had been a previous MRI of the ankle on xxxxxxx, showing anterior tibiofibular ligament chronically disrupted with mild marrow edema in the calcaneus.

The patient was still off work.

He noted that she had dysesthesia and hyperesthesia into the distal extremity. The x-rays however of the left ankle were unremarkable. considered her to be having a potential of complex regional pain disorder/RSD. He did note that she had tenderness of the Achilles tendon, the sinus tarsi as well as the peroneal retinaculum area.

The patient continued care. The patient also had care by who noted that the patient on xxxxxx, required a quad cane for ambulation. He also noted that she was having hyperesthesia of the left foot and ankle and difficulty getting from a chair and that she had limp. He diagnosed fibromyalgia which is long term with lower extremity paresthesias and evidence of RSD.

The patient had a CT scan performed on xxxxxx, which did not show any fracture. However, the MRI done the same day of the left ankle revealed likely trabecular microfracture above the talar neck but no calcaneal fracture noted. There was partial thickness tearing of the anterior talofibular ligament but also peroneus brevis degenerative tendinopathy.

The patient then had a designated doctor exam. xxxxxx, office note, noting that the designated doctor had not placed the patient at maximum medical improvement.

on xxxxxx, proposed right PTB ankle foot orthosis to unweight the right foot as well as orthotic to level her pelvis.

The patient was followed at this time in xxxxx, noting that the patient as of xxxxx, note had been able to get Miacalcin nasal spray to try to help with healing.

On xxxxxx, noted that the patient was continuing to have significant pain issues with tenderness and swelling and limitation of motion. He proposed that the patient was still disabled and that she should stay on vitamin D supplementation as well as other pain control measures.

On xxxxx, did a post-designated doctor RME. He noted her multiple diagnostic studies. He also noted that there was an MRI of the heel dated January 15, 2012, which did not reveal fracture but the May 15, 2012, MRI revealed bony contusion and likely trabecular microfracture of the talar neck. opined that the patient had not reached maximum medical improvement and that an impairment rating was not indicated. He did state that further care with to address her talar fracture as well as peroneus tendinosis was appropriate. However, the compensable injury that he outlined as related was the calcaneal fracture which had healed as well as the anterior talofibular ligament rupture and the talus microtrabecular fracture and the RSD, which he stated had resolved.

continued to follow the patient noting that she was having difficulty with the AFO. He proceeded to perform a diagnostic block of the sural nerve which did not relieve her discomfort.

On January 21, 2013, noted that the patient was having difficulty with swelling over the peroneal tendon sheath as well as diffuse tenderness between the fourth and fifth metatarsal distally. On that base the sural nerve was blocked and as noted did not provide significant benefit. Based on that, considered the peroneal tendons to be the likely origin of much of the lateral foot ankle discomfort. He therefore ordered MRI of the left ankle and foot to assess progression of her tendinosis and he outlined a surgical plan.

The patient had preauthorization request reviewed which were denied. The reconsideration request did not ever accomplish a peer to peer.

On xxxxxx, the noted the patient's worsening of pain and swelling. She had tenderness distally as well as proximally over the area of the peroneal tendons. He proposed that an MRI of the left foot and ankle would be prudent to make a surgical decision. If there was progression of the peroneal tendon pathology, surgery would be recommended.

Rationale for overturning the previous denials: As noted this patient has had a complex history of symptoms as well as care. She has not made adequate progress to be placed at maximum medical improvement per the designated doctor as well as the post-designated doctor RME. In fact, proposed that the patient return to for further care of her peroneal tendinosis as well as associated

talus changes. has requested specifically further analysis of the hindfoot and foot anatomy with the MRI to make appropriate surgical decision. This would meet ODG criteria for appropriate use of diagnostics to help in surgical planning.

Reference: ODG-TWC Foot and Ankle

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES