

FORTE

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** April 21, 2004

**RE: MDR Tracking #:** M5-04-1792-01  
**IRO Certificate #:** 5242

FORTE has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to FORTE for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

FORTE has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery) who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

In some paperwork, the claimant's name is spelled " \_\_\_\_\_", but she will be referred to as \_\_\_\_\_ throughout this report.

On 11/8/99, the claimant sustained an inversion injury to her right ankle. She was treated in the emergency room with an air cast. On 11/10/99, she visited \_\_\_\_\_, who applied a short leg cast. The cast was changed on 11/15/99 and 11/19/99 due to pain and swelling. On 11/22/99, \_\_\_\_\_ applied a Robert Jones cast to manage the swelling. On 12/6/99 an MRI of the ankle revealed findings consistent with lateral ligamentous injury. An area of edema in the subchondral bone in the medial dome of the talus was noted. \_\_\_\_\_ noted pain and swelling greater than normally expected, and a short leg walking cast was applied. On 12/22/99, \_\_\_\_\_ recommended a fracture walker, with an elastic stocking to control her (severe) swelling. Physical therapy was prescribed. On 1/7/00, \_\_\_\_\_ noted as positive Tinel's over the superficial peroneal nerve. The claimant was still using a wheelchair, and \_\_\_\_\_ recommended a stirrup brace, recommending she stay out of the wheelchair, and that the therapist work to get her out of the fracture walker and into the stirrup brace. On 2/16/00, \_\_\_\_\_ noted excellent progress, swelling down to trace plus, and he recommended physical therapy (PT) wean her out of the brace. She was returned to full duty work, with the only restriction being no work on uneven ground. On 3/7/00. The claimant reported to PT that she was awakened from sleep each night with ankle pain. On follow-up with \_\_\_\_\_

3/8/00, the claimant complained of shooting pains along the deep and superficial peroneal and the (posterior) tibial nerve at the ankle. A mass was noted over the "dorsolateral" ankle and sinus tarsi area. A repeat MRI was ordered. The repeat MRI revealed thickening of the anterior talofibular ligament, and 2 small areas of subcortical marrow edema in the talar dome without evidence of osteochondritis desiccans. On 3/22/00, \_\_\_\_\_ noted tenderness at the medial joint line and over the anserine bursa of the right knee. he noted, "this has been a problem to her but this is the first that this has been brought up to me." On 3/24/00, he additionally noted atrophy of the right quad and calf, and rather severe crepitation beneath the patella. He attributed the problems with the knee "probably as a result of the cast and her limping." PT was ordered for the right knee. On 4/19/00, \_\_\_\_\_ noted complaints of pain in her right knee and her right hip. Exam of the ankle showed no swelling, with improvement of the Tinel's. She was tender to palpation in the medial band of the plantar fascia, tenderness over the ADQ into the heel. She was referred to \_\_\_\_\_ for evaluation of her right knee, hip, and low back. She was given a heel pain program and an AFO. A MRI of the knee 5/24/00 was essentially negative. She subsequently had continued PT on her ankle, as well as on her knee and low back. After over 90 physical therapy treatments, she wrote \_\_\_\_\_ (a physiatrist also involved in her care) to request a consult to Rebecca Steiner, a physical therapist in Austin. \_\_\_\_\_ replied, "...if she provides her own transportation and living arrangements while she is there, then I have no objections..." She subsequently had therapy at \_\_\_\_\_. \_\_\_\_\_ subsequently requested consultation for deep myofascial massage, which was denied. A bone scan 1/11/01 was essentially normal, and on 1/15/01, \_\_\_\_\_ wrote that he and \_\_\_\_\_ continued to recommend deep tissue rolfing, but believed her to have reached MMI, and she was returned to full duty with no restrictions. The claimant continued to complain of pain in the ankle and knee at subsequent follow-up visits over the following several months. On 9/12/01 \_\_\_\_\_ noted the claimant had developed a new symptom of catching in the ankle. Arthroscopy was recommended. After multiple subsequent visits, arthroscopy was performed on 3/19/02. Marked adhesions were débrided from about the ankle. A posterior portal was used to drill the osteochondral defect in the medial talar dome. Subtalar arthroscopy revealed subtalar instability, and a modified Chrisman-Snook was performed. The claimant noted severe pain postoperatively, and "fracture blisters" developed secondary to swelling. \_\_\_\_\_ performed a dedicated Doctor examination on 4/29/02. At that time, he noted an MVA in her past medical history, cervical and lumbar spine injuries, and chronic back pain. Knee range of motion (ROM) at that evaluation was 13-94°. The claimant continued to receive PT, as well as independent pool therapy. Subsequently, the claimant continued to complain of pain in the ankle and knee. On 10/8/02, \_\_\_\_\_ noted her knee ROM was excellent, swelling and tenderness noted over anteromedial synovium. Water exercise was recommended. \_\_\_\_\_ requested further PT and repeat MRI. MRI 1/11/02 revealed arthrofibrosis of the ankle. \_\_\_\_\_ recommended arthroscopic debridement. This was performed 11/14/02. Severe arthrofibrosis was noted. Soft tissue massage and formal physical therapy were begun several months postoperatively. On 2/6/03, \_\_\_\_\_ noted knee ROM 0-125°. On 4/21/03 \_\_\_\_\_ noted ankle ROM roughly equal to opposite side. He recommended she do her own therapy and her own massage. On 4/25/03. The claimant saw \_\_\_\_\_, a psychologist, for pain disorder (depression and anxiety). On 4/29/03. \_\_\_\_\_ recommended supervised therapy for her knee. On the following day, she revisited \_\_\_\_\_, and, "at her insistence, (he) added soft tissue massage to the therapy session that \_\_\_\_\_ has already ordered, not in addition to it." At re-

evaluation at \_\_\_\_\_ 5/14/03, knee ROM was noted as 0-135°. At revisit to \_\_\_\_\_ 6/9/03, he noted "therapy three days a week is not seeming to function well. She is having increasing right hip and buttock pain" and therapy for ankle, knee, and hip/low back 5 days a week was prescribed. This therapy was not approved. On 11/24/03, the claimant saw \_\_\_\_\_ who noted she was not currently having symptoms related to her knee. The ankle continued to show improvement. On follow-up 1/26/04, \_\_\_\_\_ noted symmetrical ankle motion.

### **Requested Service(s)**

Physical therapy from 5/19/03 to 6/19/03.

### **Decision**

I agree with the insurance carrier that the requested intervention is not medically necessary.

### **Rationale/Basis for Decision**

\_\_\_\_\_ had recommended that the claimant perform a home program at the time of her 4/21/03. He subsequently approved further formal therapy to the ankle only as an addition to therapy prescribed by \_\_\_\_\_. The recommendation is made with multiple precautions, and with apparent reluctance. \_\_\_\_\_ treated the claimant for pain in the knee, hip, and low back. None of these areas were felt to be injured in the initial incident, but were felt to be secondary to sequelae of immobilization and gait disturbance (as a result of the ankle injury). Certainly, immobilization and disuse may result in atrophy of the extremity, as well as stiffness of adjacent joints. The loss of ROM to 13-94° described by \_\_\_\_\_ is certainly more than would be expected, however, and knee ROM improved to virtually normal by the time of the PT sessions in question. The claimant is alternately described as ambulating with the feet in pronation, ambulating on the lateral border of the foot, with the hip in flexion and abduction, and with the femur in internal rotation, and with the knee in flexion. I would expect pain from all these areas of gait disturbance would improve with normalization of the gait, and would not need to be addressed specifically with prolonged and frequent treatments with joint mobilization, 6 months following the last surgical procedure.

Pain and stiffness from an ankle injury may generalize to the affected extremity as a result of a sympathetically-mediated pain syndrome (RSD), and there are certainly some findings consistent with this. Pain, swelling, stiffness, and atrophy greater than expected were all noted at some point. This would certainly be ample justification for an unusually long and intensive period of physical therapy treatments, as indeed the claimant received. By the time of the disputed treatment, however, her swelling, stiffness, and atrophy had largely resolved, and a home program would have been appropriate.