

## Workers' Compensation - Ankle Injury and the PTP/DC Opinion

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At the time of this writing, the California legislature is poised to adopt a 15-visit-per-claim "hard cap"\* on chiropractic care in the worker's compensation system. And how many office visits did the injured claimant in the case presented below have? sixteen. One should question this "hard cap" rule; as this case review suggests, further limitations to similarly injured claimants, and all of our patients' "Bill of Rights," are on the horizon. I urge my fellow DCs to "draw the line in the sand." Frontal assault could start with unity at state and national levels, and membership in associations working for you and on your patients' behalf.

### Case History

The patient, a 56-year-old white female employee, experienced an accidental fall approximately six weeks prior, during which she fell forward onto "all fours." The employee had requested formally that I be predesignated as a personal physician, should an industrial injury occur, and I have personally treated this patient in the past. However, in this case, it appeared that her employer sent this injured claimant to another facility; the matter was remedied by the employer and workers' compensation (WC) insurance carrier, who redirected the patient to my facility for care. The patient's occupation, with the same employer for 17 years, involves motor transport; she is a driver.

The patient underwent evaluation for her work injury at the WC medical insurance carrier's facility, and was released as "cured," reportedly after six sessions of care.

The injured claimant presented to my facility in tears, stating, "I'm not lying; I can't stand on my leg; I just need a couple days off work to mend!" Her pain level was rated 8-9 on 1-10 scale, with 10 being severe pain with moderate interference in activities of daily living. The patient was in overall good health, with the exception of a clinical history of tobacco addiction and being overweight. She denied alcohol use and any previous motor vehicle accidents, work-related injuries or hospitalizations.

### Symptoms

At the time of my initial examination, the patient complained of the following:

- right-sided lower limb pain (foot) and spasm that shoots in an upward fashion on the lateral aspect of the lower leg, reportedly aggravated by motion, such as walking, commonly encountered in the workplace; and
- biaxial lumbar pain/hip pain, described as a diffuse ache.

### Examination

On clinical examination, the patient stood 5'3" and weighed 155 pounds; her pulse was 86; she

presented intolerant of affected limb weightbearing; her lumbar spinal active range of motion demonstrated was essentially full. Palpation of the hip/lumbar spine revealed tender spasm bilaterally throughout, most prominent in the right paraspinous/hip region. The right foot displayed some edema at the talar joint, and moderate tenderness to palpation, with pain on dorsiflexion with limited active range of motion. No crepitus was noted. FABERE test was normal with some limitation interpreted as capsular; not osseous.

Seated deep-tendon reflexes of the lower extremities demonstrated +2 symmetrically.

Neurological testing of the motor portion of the lower extremities that receive innervation from the lumbar region appeared unremarkable. Testing sensory discrimination to pain sensation was performed, utilizing the Buck neurological hammer. The dermatomes and their representative innervation to the foot were unremarkable.

The *tibialis posterior* (TP), *flexor digitorum longus* (FDL), and peroneus were concentrically shortened and painful to the touch. The patient's gait and balance testing demonstrated some abnormality of gait. She was unable to balance on single-leg stance. Motor demonstrated no dramatic extremity weakness. Straight-leg-rising to 80 degrees was negative. Atrophy was absent. The distal vascular exam was normal.

Chiropractic assessment yielded joint fixation of the pelvis and talar joint. Dorsiplantar and lateral-foot-limited radiographs revealed essentially normal series' unremarkable for fracture. (Pending reported medical views obtained of right ankle), there was periarticular sclerosis at the base of the cuboid and first/second cuneiform; a short first metatarsal bone; lateral deviation of the hallux; and dropped metatarsal heads (along the first and second) with slight hammertoe appearance. Bone density was normal and there was no evidence of soft tissue trophi present. There was no evidence of any frank osteolytic, osteoblastic or congenital findings, or obvious fracture.

#### Radiographic Impression

1. *hallux abducto valgus* - non-work-related injury
2. cuboid and cuneiform degenerative joint disease - non-work-related
3. ankle series, pending outside medical insurance carrier facility report/views

#### Prognosis and Disability Status

##### Subjective Factor of Disability:

1. moderate right foot pain, increasing with many activities of daily living (e.g., walking for 10 minutes or more)
2. intolerance of right lower-extremity weightbearing

##### Objective Factor of Disability:

1. provocation of pain on palpation of the right hip and ankle/foot joints
2. paraspinous spasm in the anterior talus region in the right lower extremity
3. decreased range of motion of the right ankle/foot
4. abnormal gait cycle

#### Discussion

The patient reported that her job activities required walking, prolonged standing, upper-body lifting and forward flexion activity with the right hand dominate and right foot (in the use of a pedal). She reported having been authorized to discontinue work per the previous treating physician, and was later placed onto total temporary disability status. Reportedly, after six subsequent office visits, she was deemed cured and returned to full duty. However, she reported to me that she is unable to tolerate prolonged walking, and experiences an exacerbation of her initial injury upon affected weightbearing.

#### Initial Diagnostic Impression

Sprain/strain of the right hip and right ankle/foot (secondary to fall) with lumbago.

#### Initial Work Restrictions

The patient has a disability resulting in preclusion from prolonged weightbearing; however, it is this injured claimant's desire to remain working. Reportedly, her job description is prolonged seated activity as a driver. Provided she can tolerate the dorsiflexion and plantarflexion of her right ankle, she may return to duty without restrictions, pending an outside medical management record review.

#### Initial Treatment Plan

1. Ultrasound-sonar therapy, using myofascial technique and contrast therapy with ultrasound pulsed and specific chiropractic manipulation of extaspinal joints are indicated, once inflammatory components are contained. Therapeutic exercises are prescribed, as tolerated, to target weak dorsiflexors and stretches for pedal intrinsics, such as foot doming, and TP, FDL and peroneus exert supinatory effects on the talar joint and stabilization by neurological retraining through a biomechanical ankle platform system.
2. Duration and frequency of care: 2-3 x per week x 3 weeks initial; 9 total.
3. Outcome assessment forms, to be obtained at interim.
4. Strapping of injured right extremity during the proprioceptive balance training and pain therapy care.
5. Request for record review of previous medical management rendered from carrier.

#### Initial Discussion

An interim evaluation to determine patient improvement was to be obtained in three weeks. I instructed her on her condition and my recommendations for conservative management, using anatomic models of the foot and ankle joint and anatomical charts. There were no barriers to learning apparent, and she agreed to this conservative chiropractic approach.

#### Interim 1

I continued treating this patient for the next three to four weeks and still did not receive the medical records from the WC insurance carrier on the aforementioned injured claimant to review. That is the basis for the interim report 99080, the patient's nonplateau of symptomatology, and possible need for diagnostic imaging. The patient's interim complaints (2.5 months posttrauma) on record review at this center:

1. hip pain - resolving
2. foot/ankle pain - intermittent, aggravated by prolonged weightbearing

#### Interim 1 Review of Records

The injured claimant injuries required that as the primary treating physician (PTP), I review records available and pertinent to the case. For the record, the reports available are identified below. No reports from carrier were received by the first interim.

#### Interim 1 Impression

1. lower-extremity pain, secondary to work-related injury of (date of injury) - reported 2.5-month status (post-fall)
2. lower-extremity pain, subsequent to items 1 and 2, with resultant myofascial pain syndrome
3. lumbago - resolved

#### Interim 1 Discussion

I reported to the carrier that without my review of the records to confirm my initial opinion that this injured complaint's symptomatology was a result of her work-related injury sustained on (date of injury) under (claim number), it could not be determined if not a separate entity as such under the Workman's Compensation Division rules and regulations. However, I urged that the injured claimant be allowed care, as necessary, to cure or relieve her from this injury. I was concerned that I did not have the opportunity to review any reports, progress notes, physical therapy or diagnostic imaging records from the insurance carrier's medical facility.

#### Interim 1 Treatment Plan

Obtain a foot and ankle MRI vs. bone scan (in lieu of repeating ankle X-rays) to detect any overt fracture sites or pathoanatomy and allow this injured claimant to pursue pain control under an orthopedist, such as injection therapy or short walking cast, subject to a review of MRI diagnostic yield. The medical necessity for these recommendations was apparent; she had failed to fully respond to conservative chiropractic care, and it was necessary to determine if there has been any progression in her lower-extremity condition, as it relates to traumatic insult.

#### Interim 2

Authorization for these special diagnostics was obtained and films were delivered with a medical radiological report. The injured claimant presented on second interim (3.5 months' posttrauma) to discuss the management of this condition and the urgent need for orthopedic referral.

#### Interim 2 Review of Records

The imaging center obtained on (date of study) MRI right ankle, MRI right foot. split peroneus brevis and longus tendons distal to fibula. Anterior talofibular ligament is not well-seen and possibly attenuated, due to injury. Interpretation was provided by Jane Doe, MD, and John Doe, MD. Telecom contact regarding medical management this date, with the medical radiologist, confirms my suspicion, regarding this injured claimant's traumatically induced condition and reason for nontolerance in weightbearing motion.

#### Interim 2 Impression

1. lower-extremity pain secondary to work-related injury of (DOI), reported 3.5-month status (post-fall)
2. lower-extremity pain, split peroneus brevis and longus tendon extensions to inferior calcanei, subsequent to item 1, with surgical intervention required, with ankle and foot specialist/orthopedic surgeon, per diagnostic MRI yield of (date of study)

3. lower-extremity pain subsequent to item 1, with anterior talofibular ligament injury, with orthopedic intervention required per diagnostic MRI yield of (date of study)
4. lumbago - resolved

#### Interim 2 Discussion

My review of the records confirmed my initial opinion that the patient's symptomatology was a result of her work-related injury. The injured claimant should be allowed care, as necessary, to cure or relieve her from this injury.

#### Interim 2 Work Status:

This patient was precluded from weightbearing activity involving the lower right extremity: pushoff; twisting; running; walking on uneven surfaces; and seated activity that involved the right lower extremity (those included with driving that may stress the right ankle/foot region) until orthopedic referral.

#### Interim 2 Treatment Plan:

Urgent referral was made to Dr. John Smith, orthopedic specialist, for surgical consultation of the right ankle and foot. The claims examiner was notified by way of interim reports, as completed by myself and provided to all parties. I advised that I would remain this patient's primary treating physician (PTP) and follow up once, after Dr. Smith had consulted as to the surgical management of this injured claimant.

#### Interim 3

At 4.5 months' posttrauma, the patient complained of foot/ankle pain - intermittent, aggravated by prolonged weightbearing, with posterior-to-lateral malleoli pain.

I had spoken with Dr. Smith, and the injured claimant was here to discuss the medical management of this condition. This was the basis for today's report (99080), the patient's lower-extremity symptoms, and the need for durable medical equipment, orthoses - bilateral and casting - and fitting sessions at this facility.

#### Interim 3 Review of Records

Note: No records from the medical carrier facility, as I requested from the WC carrier (three requests to date).

Dr. Smith (pending report) diagnosed semi-rigid orthoses, lower extremity; requests calf stretching, forefoot strengthening, and pre- and post-fitting.

#### Interim 3 Impression

1. lower-extremity pain, secondary to work-related injury of (date of injury) reported (now 4.5 month status, post-fall)
2. peroneal tendinopathy
3. MTP synovitis

#### Interim 3 Discussion and Treatment Plan

According to medical literature review, presented on peroneal tendon injury, acute tendinopathy

of the peroneus brevis and longus may occur after a bout of intense exercise following a prolonged period of inactivity. The peroneus longus is in jeopardy from sports involving running, cutting, and turning.

This condition is initially treated with rest, elevation, taping, and ice. The pain resolves quickly with gentle rehabilitation. Proper warmup, stretching and strengthening is recommended for patients at risk of developing tendonitis. (This injured claimant is five months' posttraumatic fall.) When conservative treatment has failed or proper rehabilitation therapy has not occurred, surgery may be offered with excision of synovium and debridement. (Recall the carrier's medical facility released as cured after six sessions; to date, I am still unclear as to what those sessions consisted of.) I am certain no taping or short walking cast was utilized.

Chronic degenerative longitudinal tears can develop in middle-aged athletes in both peroneal tendons. Treatment decisions should be targeted at symptoms, with rest followed by rehabilitation. Tears can be repaired directly at the time of surgery or grafted using plantaris or half of the peroneus brevis. Dr. Smith reported to me that due to this patient's current pain levels (now a 3), he did not feel surgical intervention was appropriate at this time. He reported that the ankle synovitis required semi-rigid orthoses and follow-up rehab sessions.

Generally, patients with this condition present with tenderness posterior to the lateral malleolus. Asking the patient to dorsiflex the foot from a position of dorsiflexion and eversion may provoke subluxation. If the tendons sublux, there will be prominence of the tendon, with dorsiflexion and internal rotation of the ankle.

An attempt at nonoperative management should involve relocating the tendons back into their groove and immobilization of the acute ankle in a cast for four weeks. Conservative treatment for acute injuries in active young athletes generally results in a 50 percent recurrence rate. Surgery may later be indicated in these patients.

Therefore, while this patient's MRI of the ankle certainly indicates such an injury, our orthopedic specialist in ankle and foot conditions prefers to remain conservative in management, based on current symptoms. (I am in agreement with him on this matter, and would prefer to avoid any surgical intervention, if possible.)

I next requested DME authorization from the carrier for L3030 x 2; custom semi-rigid orthoses; foot inserts (the removable, molded-to-patient model); and Physical Medicine and Rehabilitation code for chiropractic 97002 (re-evaluation, since she is a continuing patient) for the calf-stretching and foot-strengthening sessions.

Follow-up referral to the orthopedic specialist was scheduled in 30 days, and required authorization from the carrier - a responsibility of the PTP to obtain.

- *Editor's note:* As we go to press, California's workers' compensation bill will limit chiropractic per-claim coverage to 24 visits. A 15-visit cap was proposed during the legislative process, but does not appear to be a part of the final bill text.

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