

<b>Case Number:</b>	CM13-0050313		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/10/2012
<b>Decision Date:</b>	03/07/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Michigan, Nebraska, and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 42-year-old male who reported an injury on 4/10/12 due to squatting down to organize a shelf which caused injury to the left foot. The patient underwent an MRI that revealed medial talar dome trabecular edema and sclerosis, mild talonavicular osteoarthritis, and distal posterior tibial tendinopathy and mild Achilles tendinopathy. The patient was initially conservatively treated with a Cam walker boot, physical therapy, medications and assisted ambulation. The patient's most recent physical findings included moderate to severe tenderness over the left mid foot at the insertion of the posterior tibial tendon on the navicular with 1+ edema noted in that area and stretching of the posterior tibial causing moderate pain. The patient's diagnoses included symptomatic separation of the os navicularis of the left foot and posterior tibial tendinitis of the left foot. The patient's treatment plan included removal of the symptomatic os navicularis with ostectomy of the navicular and repair and advancement of the posterior tibial tendon.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kinder Procedure of the left foot:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wheelless Orthopedic Textbook

**Decision rationale:** The ACOEM, MTUS, and Official Disability Guidelines do not address this surgery, so other guidelines were consulted. The Wheelless Orthopedic Textbook recommends surgical intervention for this type of injury when there are physical findings of painful range of motion with tenderness over the prominence, and when it has been conservatively treated with immobilization. The clinical documentation submitted for review does provide evidence that the patient has moderate to severe left mid foot tenderness with a stiffening tendon. An MRI dated September 2010 indicated that an os navicularis prominence measured at 8 millimeters; it had increased to 11 millimeters by October 2013, as evidenced by x-ray. Additionally, the patient has been conservatively treated with activity modification and immobilization. As the patient has persistent pain complaints interfere with the patient's ability to function and ambulate independently, surgical intervention would be supported. As such, the request is medically necessary and appropriate.