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| **Case Number:** | CM14-0008506 | | |
| **Date Assigned:** | 02/12/2014 | **Date of Injury:** | 03/10/2006 |
| **Decision Date:** | 08/01/2014 | **UR Denial Date:** | 01/07/2014 |
| **Priority:** | Standard | **Application Received:** | 01/21/2014 |

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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 expert 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 59-year-old female who has submitted a claim for status post right posterior tibial tendon repoair, possible chronic regional pain syndrome of the right ankle, medial talocalcaneal osseous coalition, and possible tarsal tunnel syndrome, all associated with an industrial injury date of March 10, 2006. Medical records from 2012 through 2013 were reviewed, which showed that the patient complained of right foot and ankle pain with swelling of the ankle. She also reported that at times, her foot was cold. She also complained of tenderness and stiffness in the hind foot. Pain was rated 7-8/10. On physical examination, no sensory deficits were noted and distal pulses were intact. Ankle range of motion was limited on all planes. There was noted tenderness in the sinus tarsi area. MRI of the right ankle and hind foot to mid foot dated December 9, 2013 revealed a large medial talocalcaneal sustentacular osseous coalition, irregularity and possible scarring of the medial and lateral ankle ligament complexes, and small to moderate ankle effusion with possible synovitis with no focal osteochondral defect of talar dome identified. EMG/NCV dated January 29, 2014 revealed electrical evidence of right distal tibial neuropathy consistent with tarsal tunnel syndrome. Treatment to date has included medications, ankle stabilizer braces, physical therapy, a home exercise program, ankle steroid injection, right posterior tibial tendon repair, and right lumbar sympathetic blocks.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right tarsal tunnel release, possible excision talocalcaneal coalition, use of arthrex arthroflex:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines and International consensus. Acellular matrices for the treatment of wounds. An expert working group review. London: Wounds International, 2010.

**Decision rationale:** The California MTUS does not specifically address surgery for tarsal tunnel syndrome and acellular matrices for the treatment of wounds, so the Official Disability Guidelines and the article entitled Acellular matrices for the treatment of wounds, published by Wounds International were used instead. The Official Disability Guidelines states that surgery for tarsal tunnel release is recommended after conservative treatment for at least one month. Patients with clinical findings and positive electrodiagnostic studies of tarsal tunnel syndrome warrant surgery when significant symptoms do not respond to conservative management. When conservative therapy fails to alleviate the patient's symptoms, surgical intervention may be warranted since space-occupying masses require removal. Regarding acellular matrices, wounds international states that currently there is no definitive paper or guideline on the use of acellular matrices in acute and chronic wounds. The article further states that acellular matrices should be considered in wounds that are unresponsive to traditional wound management modalities or present as a complex surgical wound. In this case, the request for right tarsal tunnel release, possible excision talocalcaneal coalition was made because the requesting physician was thinking that the compression of the tarsal tunnel may be giving the patient her symptoms and they will see if surgical release and excision of fibrous coalition will be helpful. The diagnosis of tarsal tunnel syndrome was supported by clinical and electrodiagnostic findings. imaging findings further corroborated the diagnosis by demonstrating a large talocalcaneal coalition encroaching on the tibial nerve. Thus, the need for right tarsal tunnel release, possible excision talocalcaneal coalition was established. However, a discussion or rationale was not provided regarding the use of Arthrex Arthroflex. Although right tarsal tunnel release, possible excision talocalcaneal coalition may be appropriate, further information is needed to determine the medical necessity of the use of Arthrex Arthroflex. Therefore, the request, as submitted, was not medically necessary.