MAXIMUS Federal Services

Case Number:	CM14-0106183		
Date Assigned:	07/30/2014	Date of Injury:	11/12/2012
Decision Date:	08/29/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/09/2014

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 claimant is a 50-year-old gentleman injured in a work-related accident on November 12, 2012. The records provided for review document a fifth metatarsal base fracture, which was treated conservatively. More than 18 months later, a follow-up report dated June 5, 2014, documented the acute onset of swelling and pain with diminished function. Physical examination showed a full range of motion of the ankle with tenderness to palpation over the fifth metatarsal and diminished sensation in a distal distribution. Plain-film radiographs showed increased valgus displacement with increased lysis at the area of prior healing. Based on the claimant's current clinical presentation and increased pain, this request is for: an open reduction internal fixation procedure; peroneus longus to brevis tendon transfer and plantar fascial release; a two-day inpatient hospital stay; post-operative follow up visit; and post-operative radiologic assessment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Two day inpatient hospital stay.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Treatment Index: Forearm, Wrist and Hand Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: ankle procedure Ankle Repair (icd 81.49 - Other repair of ankle)Actual data -- median 2 days; mean 2.5 days (Â±0.3); discharges 1,018; charges (mean) $31,344Best practice target (no complications) -- 2 days.

Decision rationale: The request for surgical intervention is not established as medically necessary in this case. Therefore, the request for pre-operative medical clearance is not medically necessary.

One open reduction and internal fixation of the right fifth metatarsal fracture with possible calcaneal bone graft, peroneous langus to brevis tendon transfer and planter fascial release.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Treatment Index Ankle and Foot Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: ankle procedure -Open reduction internal fixation (ORIF)Recommended as an option for fractures when radiographic evidence indicates a displaced fracture or comminuted fracture, or an open fracture with bone protrusion. Open reduction internal fixation (ORIF) is a method of surgically repairing a fractured bone, in which surgery is used to reduce or set the fracture fragments and then hardware (such as a rod, plate and/or nails) is then implanted to hold the reduction in place. (Lange, 2007)Peroneal tendinitis/ tendon rupture (treatment)Recommend conservative treatment for tendinitis, and surgery as an option for a ruptured tendon. Patients with peroneal tendonitis, but no significant peroneal tendon tear, can usually be treated successfully non-operatively. In patients with a large peroneal tendon tear or a bony prominence that is serving as a physical irritant to the tendon, surgery may be beneficial. Peroneal tendonitis is an irritation to the tendons that run past the back outside part of the ankle, and it is a common cause of lateral ankle pain. Commonly it is an overuse condition that responds to conservative treatment, but if it is left untreated it can progress to a complete tendon rupture. Predisposing factors for peroneal tendonitis and rupture include varus alignment of the hindfoot and peroneal subluxation and dislocation. Participation in certain sports, including downhill skiing, skating, ballet, running and soccer creates higher risk for peroneal tendon tears. If caught early, peroneal tendonitis or instability may be treated conservatively with NSAIDs, immobilization and avoidance of exacerbating activities. Once secondary changes in the tendon occur, however, surgical treatment often becomes necessary. Surgery is indicated in the acute phase for peroneus brevis tendon rupture, acute dislocation, anomalous peroneal brevis muscle hypertrophy, and in peroneus longus tears that are associated with diminished function. (Cerrato, 2009)Surgery for plantar fasciitisNot recommended execept as indicated below. No randomized trials evaluating surgery for plantar heel pain against a control group have been identified; therefore no conclusions can be drawn. (Crawford, 2002) Generally, surgical intervention may be considered in severe cases when other treatment fails. In general, heel pain resolves with conservative treatment. In

recalcitrant cases, however, entrapment of the first branch lateral plantar nerve should be suspected. Surgical release of this nerve can be expected to provide excellent relief of pain and facilitate return to normal activity. (Baxter, 1992) Nonsurgical management of plantar fasciitis is successful in approximately 90% of patients. Surgical treatment is considered in only a small subset of patients with persistent, severe symptoms refractory to nonsurgical intervention for at least 6 to 12

Decision rationale: California MTUS ACOEM Guidelines and the Official Disability Guidelines, would not support open reduction and internal fixation of the right fifth metatarsal fracture with possible calcaneal bone graft, peroneous langus to brevis tendon transfer and planter fascial release in this case. While the claimant is noted to have lysis changes on radiographs, the reviewed records do not document acute clinical findings on imaging that would support the need for delayed open reduction and internal fixation. Furthermore, given the claimant's clinical presentation, there is no indication of the need for peroneal tendon transfer or plantar fascial release. Absent acute pathology and the documentation of findings specific to the claimant's plantar fascia or peroneal tendons, this request would not be established as medically necessary.

One post operative follow-up visit.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Therapeutic Office Visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp, 18th Edition, 2013 Updates: ankle procedureOffice visitsRecommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the

recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy.

Decision rationale: The request for surgical intervention is not established as medically necessary in this case. Therefore, the request for one post-operative visit is not medically necessary.

One post operative x-ray of the right foot.: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 372, 373, 374.

Decision rationale: The request for surgical intervention is not established as medically necessary in this case. Therefore, the request for one post-operative plain-film radiography is not medically necessary.