

Case Number:	CM14-0117072		
Date Assigned:	08/04/2014	Date of Injury:	02/11/2014
Decision Date:	09/10/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/24/2014

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 Podiatric Surgery and is licensed to practice in New York. 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:

According to the enclosed information the original date of injury for this patient was 2/11/2014. On 4/30/2014 patient was evaluated by his physician. Patient continues to complain of a sharp pain to the left Achilles insertion area. Patient states that he has tried rest, medications, immobilization, and a home stretching program. Nothing apparently is helping. An MRI dated April 1, 2014 reveals 50% partial tear of the Achilles tendon. The physicians states that because the patient does not appear to be improving he is a candidate for a left Achilles Reconstruction. The physician also request preoperative clearance as well as postoperative physical therapy. Physical exam this day reveals 4 + pain upon palpation to the Achilles tendon insertion area, with a intact squeeze test, although painful. Again, because patient has apparently failed conservative treatments, this position would like patient to undergo Achilles tendon reconstruction.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT Achilles Reconstruction Surgery.: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Ankle and foot.

Decision rationale: After careful review of the provided information and the pertinent MTUS guidelines for this case, it is my feeling that the decision for left Achilles Reconstruction surgery is not medically reasonable or necessary for this patient at this time. The progress notes do advise that patient has attempted conservative treatments to alleviate pain from his Achilles tendon insertion. By all accounts these conservative treatments have been attempted by the patient for only two months. An MRI taken in early April does reveal 50% partial tear of the Achilles tendon. ODG guidelines state that open operative treatment of acute Achilles tendon ruptures significantly reduces the risk of rerupture compared to non-operative treatment, but produces a significantly higher risk of other complications, including wound infection. The latter may be reduced by performing surgery percutaneously. Post-operative splintage in a functional brace appears to reduce hospital stay, time off work and sports, and may lower the overall complication rate. (Khan-Cochrane, 2004) Six months of nonsurgical therapy is appropriate for middle-aged patients or athletes with chronic Achilles tenosynovitis. Those that fail this treatment will improve with a limited debridement of diseased tissue without excessive soft tissue dissection of the tendon. Those patients who respond to nonoperative therapy tend to be younger than those who have degenerative tendon changes requiring surgery. (Johnston, 1997) Open operative treatment of acute Achilles tendon ruptures significantly reduces the risk of rerupture compared with nonoperative treatment, but operative treatment is associated with a significantly higher risk of other complications. Operative risks may be reduced by performing surgery percutaneously. Postoperative splinting with use of a functional brace reduces the overall complication rate. (Khan, 2005) Comparisons of surgically and nonsurgically treated Achilles tendon ruptures have demonstrated that those treated with surgery allow earlier motion and tend to show superior results. However, early motion enhances tendon healing with or without surgery and may be the important factor in optimizing outcomes in patients with Achilles tendon rupture. This RCT supports early motion (progressing to full weightbearing at 8 weeks from treatment) as an acceptable form of rehabilitation in both surgically and nonsurgically treated patients with comparable functional results and a low rerupture rate. According to the progress notes, this patient has not failed 6 months of conservative treatment to his Achilles tendon. For this reason, surgical repair is not medically necessary.

Pre-op Physical Clearance Chem 7, UA, CBC, H&P: Upheld

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 Official Disability Guidelines (ODG) : Ankle and foot.

Decision rationale: After careful review of the information and the pertinent MTUS guidelines for this case, it is my feeling that the decision for left Achilles Reconstruction surgery is not medically reasonable or necessary for this patient at this time. The progress notes do advise that patient has attempted conservative treatments to alleviate pain from his Achilles tendon insertion. By all accounts these conservative treatments have been attempted by the patient for

only two months. An MRI taken in early April does reveal 50% partial tear of the Achilles tendon. ODG guidelines state that open operative treatment of acute Achilles tendon ruptures significantly reduces the risk of rerupture compared to non-operative treatment, but produces a significantly higher risk of other complications, including wound infection. The latter may be reduced by performing surgery percutaneously. Post-operative splintage in a functional brace appears to reduce hospital stay, time off work and sports, and may lower the overall complication rate. (Khan-Cochrane, 2004) Six months of nonsurgical therapy is appropriate for middle-aged patients or athletes with chronic Achilles tenosynovitis. Those that fail this treatment will improve with a limited debridement of diseased tissue without excessive soft tissue dissection of the tendon. Those patients who respond to nonoperative therapy tend to be younger than those who have degenerative tendon changes requiring surgery. (Johnston, 1997) Open operative treatment of acute Achilles tendon ruptures significantly reduces the risk of rerupture compared with nonoperative treatment, but operative treatment is associated with a significantly higher risk of other complications. Operative risks may be reduced by performing surgery percutaneously. Postoperative splinting with use of a functional brace reduces the overall complication rate. (Khan, 2005) Comparisons of surgically and nonsurgically treated Achilles tendon ruptures have demonstrated that those treated with surgery allow earlier motion and tend to show superior results. However, early motion enhances tendon healing with or without surgery and may be the important factor in optimizing outcomes in patients with Achilles tendon rupture. This RCT supports early motion (progressing to full weightbearing at 8 weeks from treatment) as an acceptable form of rehabilitation in both surgically and nonsurgically treated patients with comparable functional results and a low rerupture rate. Due to the requested surgery not meeting ODG guidelines, the preoperative physical clearance including a CBC, chem 7, UA, and H&P is not medically necessary.

Post op Physical Therapy 2x6.: Upheld

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 Official Disability Guidelines (ODG) : Foot and Ankle.

Decision rationale: After careful review of the provided information and the pertinent MTUS guidelines for this case, it is my feeling that the decision for left Achilles Reconstruction surgery is not medically reasonable or necessary for this patient at this time. The progress notes do advise that patient has attempted conservative treatments to alleviate pain from his Achilles tendon insertion. By all accounts these conservative treatments have been attempted by the patient for only two months. An MRI taken in early April does reveal 50% partial tear of the Achilles tendon. ODG guidelines state that open operative treatment of acute Achilles tendon ruptures significantly reduces the risk of rerupture compared to non-operative treatment, but produces a significantly higher risk of other complications, including wound infection. The latter may be reduced by performing surgery percutaneously. Post-operative splintage in a functional brace appears to reduce hospital stay, time off work and sports, and may lower the overall complication rate. (Khan-Cochrane, 2004) Six months of nonsurgical therapy is appropriate for middle-aged patients or athletes with chronic Achilles tenosynovitis. Those that fail this

treatment will improve with a limited debridement of diseased tissue without excessive soft tissue dissection of the tendon. Those patients who respond to nonoperative therapy tend to be younger than those who have degenerative tendon changes requiring surgery. (Johnston, 1997) Open operative treatment of acute Achilles tendon ruptures significantly reduces the risk of rerupture compared with nonoperative treatment, but operative treatment is associated with a significantly higher risk of other complications. Operative risks may be reduced by performing surgery percutaneously. Postoperative splinting with use of a functional brace reduces the overall complication rate. (Khan, 2005) Comparisons of surgically and nonsurgically treated Achilles tendon ruptures have demonstrated that those treated with surgery allow earlier motion and tend to show superior results. However, early motion enhances tendon healing with or without surgery and may be the important factor in optimizing outcomes in patients with Achilles tendon rupture. This RCT supports early motion (progressing to full weightbearing at 8 weeks from treatment) as an acceptable form of rehabilitation in both surgically and nonsurgically treated patients with comparable functional results and a low rerupture rate. Because the requested surgery does not meet the ODG guidelines, the post operative physical therapy is not medically necessary.