Case Number:	CM14-0181411		
Date Assigned:	11/06/2014	**Date of Injury:**	05/02/2009
Decision Date:	12/30/2014	**UR Denial Date:**	10/17/2014
Priority:	Standard	**Application Received:**	10/31/2014

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:

This is a 47-year old male with a 5/2/09 injury date. A right forefoot MRI on 11/20/13 showed mild 1st metatarsophalangeal (MTP) joint arthrosis and stress reaction involving the tibial sesamoid and multiple hammertoe deformities. A right ankle MRI on 11/20/13 revealed severe tenosynovitis of both peroneal tendons inciting a mild reactive bone marrow edema pattern at the plantar lateral margin of the calcaneus and a large irregular os peroneum with a mild degenerative stress reaction. In a 10/7/14 follow-up, the patient complained of right foot and ankle pain that prevent him from performing regular activities and his job. He had residual pain since his 2011 foot surgery. He had pain in the 2nd, 3rd, and 4th metatarsal head and retracted hammertoe deformities. Objective findings included pain and edema over the lateral aspect of the ankle, posterior distal fibular region, and lateral calcaneal wall. There was a cocked hallux, and cocked toes 2-5 due to significant pes cavovarus deformity and callus formation to the plantar aspects of the 1st-5th metatarsal heads. There was callus to the lateral aspect of the calcaneus, causing significant pain. There was inversion of the subtalar joint, up to about 30 degrees, however, eversion did not pass beyond 2 degrees. Diagnostic impressions: right foot congenital cavovarus deformity, metatarsalgia, declination 1st metatarsal, hammertoe deformities 2-5. Treatment to date: left foot peroneal tendon repair and 1st ray dorsiflexion osteotomy (2011), medications, custom orthotic. A UR decision on 10/16/14 denied the request for right foot lateral sliding calcaneal osteotomy, forefoot correction, hammertoe deformity correction, and MTP joint extensor tendon lengthening/capsulotomy because there was no documentation of prior conservative treatment options such as immobilization, rest, ice, NSAIDS, orthoses, or physical therapy. In addition, there were no MRI findings of acute calcaneal injury and the deformity is stated to be congenital in nature.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right foot lateral sliding calcaneal osteotomy: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Nagai MK, Chan G, Guille JT, Kumar SJ, Scavina M, Mackenzie WG. Prevalence of Charcot-Marie-Tooth disease in patients who have bilateral cavovarus feet. J Pediatr Orthop. 2006 Jul-Aug;26(4):438-43

Decision rationale: CA MTUS and ODG do not address this issue. A calcaneal osteotomy comprises cutting the heel bone and shifting it toward the inside (medial) or outside (lateral). A calcaneal osteotomy is indicated for patients whose hind foot alignment is significantly offset and for whom non-operative management has failed. However, the documentation indicated that the patient's cavovarus deformity is congenital in nature, of which the most common type is Charcot-Marie-Tooth (CMT) disease. It does not appear from the records that the deformity is related to a work-place injury. The nature and mechanism of the patient's foot injury, as well as the condition of the foot prior to the injury, is not mentioned in the records. This information would be necessary prior to certification. Therefore, the request for right foot lateral sliding calcaneal osteotomy is not medically necessary.

Forefoot correction including dorsiflexory osteotomy of 1st metatarsal and shortening osteotomy of metatarsals 2-5.: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Trnka HJ, Gebhard C, Muhlbauer M, Ivanic G, Ritschl P. The Weil osteotomy for treatment of dislocated lesser metatarsophalangeal joints: good outcome in 21 patients with 42 osteotomies. Acta Orthop Scand. 2002 Apr;73(2):190-4

Decision rationale: CA MTUS and ODG do not address this issue. According to Trnka et al, shortening osteotomies of the metatarsals are frequently used in the treatment of metatarsalgia. According to The Weil osteotomy is an oblique osteotomy of the metatarsal neck and shaft, parallel to the ground surface, which controls shortening of the metatarsal by internal fixation with screws or pins. However, it is not clear from the available records if any conservative treatment methods have been tried for the patient's forefoot deformity/metatarsalgia, other than the custom orthosis that was recently obtained. In addition, it is not clear if the forefoot deformity is part of the overall congenital cavovarus deformity or if it was acquired in the work-place injury 4 years ago. The nature and mechanism of the patient's foot injury, as well as the condition of the foot prior to the injury, is not mentioned in the records. This information would be necessary prior to certification. Therefore, the request for forefoot correction including

dorsiflexors osteotomy of 1st metatarsal and shortening osteotomy of metatarsals 2-5 is not medically necessary.

Correction of hammertoe deformities digits 1-5: Upheld

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

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 Chapter--Surgery for hammertoe syndrome

Decision rationale: CA MTUS does not address this issue. ODG states that nonsurgical treatment of hammertoe is often the initial treatment choice for the symptomatic digital deformity. Various padding techniques exist, serving to cushion or offload pressure points that may involve both the affected toe(s) as well as its respective metatarsal head plantarly. Orthotic devices or shoe insole modifications using a metatarsal pad may offer relief of excessive metatarsal head pressures. Debridement of associated hyperkeratotic lesions usually is effective in helping to reduce symptoms. If local inflammation or bursitis exists, a corticosteroid injection into the affected area may be beneficial. Taping to reduce and splint flexible deformities may be performed, especially in the setting of an early crossover second toe deformity. Finally, footwear changes such as a wider and/or deeper toe box may be used to accommodate the deformity and decrease shoe pressure over osseous prominences. However, it is not clear from the available documentation if any of these conservative techniques have been attempted. The patient may be a candidate for hammertoe correction, but it would not be advisable until the congenital cavovarus deformity is corrected, which does not appear to be work-related. Therefore, the request for correction of hammertoe deformities digits 1-5 is not medically necessary.

Extensor tendon lengthening and capsulotomy of metatarsophalangeal joints 1-5: Upheld

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

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 Chapter--Surgery for hammertoe syndrome Dhukaram V, Hossain S, Sampath J, Barrie L. Correction of hammer toe with an extended release of the metatarsophalangeal joint. J Bone Joint Surg [Br]. 2002;84-B:986-90

Decision rationale: CA MTUS does not address this issue. ODG states that nonsurgical treatment of hammertoe is often the initial treatment choice for the symptomatic digital deformity. Dhukaram et al described extensor tendon lengthening and MTP joint capsulectomy in the treatment of hammertoe deformity. However, it is not clear from the available documentation if any appropriate conservative techniques have been attempted. The patient may be a candidate for hammertoe correction, but it would not be advisable until the congenital cavovarus deformity is corrected, which does not appear to be work-related. Therefore, the

request for extensor tendon lengthening and capsulectomy of metatarsophalangeal joints 1-5 is not medically necessary.