

Case Number:	CM14-0201002		
Date Assigned:	12/11/2014	Date of Injury:	05/03/2013
Decision Date:	01/27/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/01/2014

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 Emergency Medicine 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 67 year old female with a work injury dated 05/06/2013 resulting in "persistent and progressive painful deformity" in her right foot. In the operative note dated 04/29/2014 (present in the submitted records) the provider notes the injured worker (IW) had failed non-operative treatment. Magnetic resonance imaging (MRI) (report not in submitted records) is documented by the provider as demonstrating evidence of significant posterior tibial tendinopathy. The provider also notes that clinical exam was consistent with MRI findings and the IW had significant lateral impingement. The provider stated he felt surgical treatment was indicated. On 04/29/2014 the following procedures were preformed:- Debridement, synovectomy posterior tibial tendon right foot- Right subtalar synovectomy right foot- Flexor digitorum longus tendon transfer right foot- Deltoid ligament reconstruction right foot- Medial transitional calcaneal osteotomy right foot Post-operative treatment consisted of a cast and non-weight bearing until 06/13/2014 at which time she was placed in a short leg fiberglass cast and fitted with a cast shoe. She was advised she could begin weight bearing to tolerance in the cast. Right foot x-rays were documented as showing good correction of the foot alignment. On 07/11/2014 the cast was removed and the IW was fitted with a removable boot to wear for standing and walking. Documentation reveals "tendon transfer seems to be functioning well." Right foot x-rays were documented as showing progressive healing with intact screw fixation. On 08/01/2014 at follow up visit the IW was fitted with an air-stirrup brace. Physical exam revealed moderate edema. Pulses, sensation and motor were intact. Right foot x-ray is documented as showing stable alignment and fixation with progressive healing and good alignment. Office visit dated 10/03/2014 noted the IW was not wearing the air-stirrup brace but was wearing a good supportive boot. Work status was restricted to a 6 hour work day; however she was not able to return to work as place of employment could not provide modified duty. On 10/31/2014 the IW

was given a release to return to full duty at work as of 11/01/2014. Physical exam revealed mild residual pronation of the right foot and ankle. She had good range of motion and some mild restriction of dorsiflexion and plantar flexion and walked with a mild residual limp. Pulses, sensation and motor were intact. (Actual x-ray reports are not in the submitted records.) Prior medical history included hypertension treated with three oral medications. She was also taking Aspirin 81 mg as an anti-coagulant. Two physical therapy notes are present in the submitted record with a documented number of visits as 7. In review of the submitted records it is noted that post-operative physical therapy two times six was certified. On 08/01/2014 the provider requested to extend post-operative physical therapy 60 days (2 times a week for 6 weeks). The total number of visits completed is not documented. On 11/17/2014 the provider recommended additional physical therapy to optimize her function and requested additional physical therapy two times per week for 4 weeks. On 11/24/2014 utilization review issued a decision modifying the request to 4 sessions to include HEP, stating: Consideration for additional sessions will need documentation of the number of PT visits completed. Guidelines cited were MTUS 2009 ACOEM, Occupational Medicine Practice Guidelines, 2nd Edition, 2004, Chapter 14 pages 369-370 regarding ankle and foot complaints.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy, quantity 8: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369-370.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 12-13.

Decision rationale: As per California MTUS Post-Surgical Treatment Guidelines, patient's surgery is not specified but falls under above surgical heading. Physical therapy (PT) has reported good home directed therapy program and is making good progress with full return to duty. Request was made to "optimize function". There is no total number of PT sessions completed but at least 12 was approved in the past. While patient's procedure is more complicated than a basic posterior tibial tendon rupture, all recommendations as per Post-Surgical treatment guidelines recommend up to 6months of post-operative therapy which has been completed. Patient has made good progress and is using skills learned during sessions for home directed exercise and therapy sessions. Number of prior PT sessions already exceed MTUS recommendations. Additional sessions do not meet criteria for recommendation. Additional physical therapy is not medically necessary.