

<b>Case Number:</b>	CM15-0016088		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	08/20/2014
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 36 year old male, who sustained an industrial injury on August 20, 2014. He has reported injury to his left lower extremity when he twisted his ankle. The diagnoses have included possible longitudinal partial thickness tear of posterior tibialis tendon and sprain/strain of the left ankle. Treatment to date has included physical therapy, CAM walker, medications and diagnostic studies. Examination of the left ankle on 9/9/2014 revealed no swelling. There was tenderness on the anterolateral aspect with a normal gait but no ecchymosis, no Achilles tendon tenderness or plantar fascia tenderness. Arch anatomy was normal. X-rays of the left ankle were negative. An MRI scan of the left ankle dated 9/24/2014 revealed slightly increased T2 hyperintense intensity along the fibers of the tibiotalar ligament with intact fibers noted. The rest of the deltoid ligament appeared intact. The anterior and posterior talofibular ligaments were unremarkable. The calcaneofibular ligament was intact. The spring ligament was intact. There was thickening with intermediate signal noted in the tendon of the tibialis posterior along the lateral aspect of the talar neck which was suggestive of tendinosis versus partial thickness tear. A full-thickness tear was not seen. An area of T2 hyperintensity surrounded the peroneal tendons in the retromalleolar region. This may be due to trauma and soft tissue edema or early tenosynovitis. On November 28, 2014 the progress notes indicated a diagnosis of tenosynovitis of peroneal tendons, left and sprain/strain of ankle, left. An injection of Depo-Medrol and lidocaine was given into the left ankle. Sedentary work was advised with use of a cam walker. On December 4, 2014 there was no improvement documented. He was complaining of pain along the lateral aspect of the ankle joint. On December 18, 2014 he had completed 2 sessions of

physical therapy which did not help. He reported temporary relief with oral medications and topical creams. Examination documented swelling on the medial aspect of the left foot along the posteromedial aspect, along the posterior tibial tendon at the lateral aspect of the talus specifically. Currently, the injured worker complains of numbness on the right side due to overuse and an increase in left knee pain. He reported that the physical therapy did not help him. He experienced temporary relief with oral medications and topical creams. He has difficulty with ambulation and weightbearing and continues to use his CAM walker. On January 21, 2015, Utilization Review non-certified a request for repair of the posterior tibial tendon, pre-op labs/EKG/chest x-ray and assistant surgeon, noting the CA MTUS/ACOEM and Official Disability Guidelines. On January 28, 2015, the injured worker submitted an application for Independent Medical Review for review of repair of the posterior tibial tendon, pre-op labs/EKG/chest x-ray and assistant surgeon.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Repair of the posterior tibial tendon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127; Official Disability Guidelines (ODG), Foot and Ankle.

**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), Ankle and Foot, Posterior tibial tendon repair.

**Decision rationale:** California MTUS guidelines indicate surgical considerations for activity limitation for more than one month without signs of functional improvement, failure of exercise programs to increase range of motion and strength of the musculature around the ankle and foot, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The MRI scan did not show a clear imaging evidence of rupture of the posterior tibial tendon. ODG guidelines for posterior tibial tendon dysfunction indicate an initial period of rest, nonsteroidal anti-inflammatory drugs, and immobilization of the foot for 6-8 weeks with a rigid below-knee cast or boot to prevent overuse. After the cast is removed, shoe inserts such as a heel wedge or arch support may be helpful. If the condition is advanced, a custom-made ankle-foot orthosis or support may be necessary. If conservative treatments don't work surgery is necessary. The function of the posterior tibial tendon is to stabilize the hindfoot against valgus and eversion forces. It functions as the primary invertor of the foot and assists the Achilles tendon in plantar flexion. Acute injuries of the posterior tibial tendon are rare and mostly affect the active middle-aged patient or there are the results of complex injuries to the ankle joint complex. Degeneration and rupture is seen with advancing age, comorbidities, and obesity. In this case, the MRIs scan was equivocal and did not show a definite rupture. The pain was on the lateral aspect and not over the tendon. The MRI scan also showed an area of hyperintensity surrounding the peroneal tendons in the retromalleolar region which may be due to trauma or early tenosynovitis. A rupture of the tibialis posterior tendon at

such a young age would be extremely unlikely. In the absence of a definitive evidence of rupture on the imaging studies, surgery is not indicated. The documentation does not indicate use of shoe inserts such as a heel wedge or arch support or a custom-made ankle-foot orthosis. As such, the guidelines do not support the request for surgery for the posterior tibial tendon and the medical necessity of the request has not been substantiated.

**Associated surgical services: assistant surgeon:** 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): 374.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-op labs, EKG, chest x-ray:** 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): 374.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.