MAXIMUS Federal Services

Case Number:	CM15-0206216		
Date Assigned:	10/23/2015	Date of Injury:	06/27/2013
Decision Date:	12/07/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/20/2015

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: Illinois, California, Texas
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:

This injured worker is a 34-year-old female who sustained an industrial injury on 6/27/13. Injury occurred while she was lifting a 40-pound dog and dislocated her left hip. She subsequently developed compensatory left foot and ankle pain. Past medical history was positive for diabetes, cardiac disease, and current every day smoking. The 2/23/15 left foot MRI documented a normal examination. The 2/23/15 left ankle MRI conclusion documented the pain marker was adjacent to the peroneal tendons and a hypertrophied peroneal tubercle. There was no tenosynovitis however there may be occult irritation of the tendons by the tubercle. The Achilles tendon was documented as normal. There was hindfoot valgus noted with a tibio-calcaneal angle of 33 degrees. There was a small focus of bone marrow edema in the medial surface of the distal fibula suggestive of early subfibular impingement. There was mild tendinosis of the posterior tibialis. The 5/15/15 physical therapy report documented the injured worker had completed 8 sessions of physical therapy for her Achilles tendonitis. Range of motion had improved 10 degrees in active dorsiflexion to -10 degrees and strength had improved from 4/5 to 5/5. She continued to have an abnormal gait with no lateral weight bearing and not enough dorsiflexion. The 9/8/15 left ankle CT scan impression documented a normal left ankle study. The 9/18/15 left foot CT scan impression documented a normal left foot study. The 9/18/15 podiatry report cited pain over the left foot and ankle with inability to place her heel directly on the floor, decreased motion of the foot and ankle, painful lump on the lateral foot distal to the ankle, some foot swelling, and pain with walking, standing, and shoes. She was unable to tolerate the night splint. Since the original injury, her left foot had become plantar-flexed and her Achilles/gastrocnemius underwent

flexion contracture due to walking on her toes. She had developed a pain over lateral left foot at a prominent peroneal tubercle that was causing irritation of the peroneal tendons in the area. She had tried insoles in her shoes, completed physical therapy, and had been doing stretching exercises. Physical exam documented an antalgic gait protecting her left foot and ankle. There was pain with palpation of the lateral foot at the peroneal tubercle and adjacent peroneal tendons with visible enlargement of the tubercle. There was a flexion contracture of the left Achilles/ gastrocnemius with 20 degrees of equinus at the ankle, and pain with palpation of the Achilles tendon along its course and at the insertion in the calcaneus. There was local tendon area edema and decreased sensation of the lateral left foot about the calcaneus. There were normal lower extremity reflexes and sensation. The diagnosis was Achilles tendon contracture, hypertrophy of bone, peroneal tendonitis, acquired equinus, and pain. The treatment plan recommended Achilles lengthening following smoking cessation for 6 weeks. Authorization was requested for Achilles tendon lengthening. The 9/28/15 utilization review non-certified the request for Achilles tendon lengthening as there was no documentation of physical therapy provided to the injured worker and the treating physician's discussion indicated that the injured worker was not a candidate until she had stopped smoking for at least 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Achilles tendon lengthening: Overturned

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Shu H, Ma B, Kan S, Wang H, Shao H, Watson JT. Treatment of posttraumatic equinus deformity and concomitant soft tissue defects of the heel. J Trauma. 2011 Dec; 71 (6): 1699-704. doi: 10.1097/TA.0b013e3182396320.

Decision rationale: The California MTUS guidelines recommend surgical consideration when there is activity limitation for more than one month without signs of functional improvement, and exercise programs had failed to increase range of motion and strength. Guidelines require clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. Peer reviewed literature generally support Achilles tendon lengthening for equinus deformities. Evidence based medical guideline and peer reviewed criteria have been met. This injured worker presents with a 10-degree dorsiflexion contracture with difficulty ambulating. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. This surgical intervention is reasonable to treat the post-traumatic equinus deformity and for functional restoration of ambulation. Therefore, this request is medically necessary.