

Case Number:	CM15-0023590		
Date Assigned:	02/13/2015	Date of Injury:	07/24/2013
Decision Date:	03/30/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/09/2015

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:

The injured worker is a 45 year old female with an industrial injury dated 7/24/13 when she tripped and fell over a rug. Past medical history was positive for obesity, hypertension, and diabetes. The 10/14/13 right ankle MRI impression documented posterior tibialis tendinosis with possible intrasubstance tear. There was minimal posterior tibialis tenosynovitis. There was evidence of prior injury along the superomedial aspect of the spring ligament. The 10/13/14 medical legal report cited persistent right ankle pain. Diabetic control was reported erratic, and the obesity situation was suboptimal with a body mass index over 50. Medial ankle pain was worsened with prolonged weight bearing or walking. Physical exam documented fairly localized tenderness over the sinus tarsi region and swelling over the posterior tendon region. There was a loss of arch on the right compared to the left when seated, and marked flat feet bilaterally when standing. Conservative treatment was recommended to include non-steroidal anti-inflammatory drug, bracing, and possible corticosteroid injections. Surgery was not recommended at this time. The 11/17/14 treating physician report indicated that there was no change in right ankle symptoms. The patient had a flatfoot deformity with tenderness over the posterior tibial tendon, tight Achilles tendon, mild tenderness over the sinus tarsi, and no neurovascular deficits. The injured worker was reported as non-compliant with medication and the treatment plan, not taking her diabetic medications regularly. She had been enrolled in weight management and pattern management education but had not been compliant with instructions given to her. She was reported capable of modified duty. Her diagnoses included bilateral pre-existing flatfeet, right tibialis tendinitis, right posterior tibial tendon tear and degeneration, and right sinus tarsi

ganglion cyst. The treatment plan recommended right posterior tibial tendon excision, calcaneal lengthening osteotomy, calcaneal medializing osteotomy, and flexor digitorum longus tendon to posterior tibial tendon/navicular transfer, iliac crest bone graft allograft, percutaneous tendoachilles lengthening, and excision of sinus tarsi ganglion cyst. The 12/30/14 treating physician report indicated that the patient's hgA1c was now 7.1, which reduced the risk of wound infection. He opined that the patient would not be able to lose weight at the current level of mobility, as her foot and ankle pain were to some degree responsible for her limited mobility. The proposed surgery would reduce her foot and ankle pain. On 01/22/2015, Utilization Review non-certified a request for right posterior tibial tendon excision, calcaneal lengthening osteotomy, calcaneal medializing osteotomy, flexor digitorum longus tendon to posterior tibial tendon/navicular transfer, iliac crest bone graft allograft, percutaneous tendoachilles lengthening, excision of sinus tarsi ganglion cyst, noting that there was no documentation of conservative treatments, orthotic bracing, physical therapy or activity modification, and no imaging studies to confirm pathology of the hind foot or pathology involving the posterior tibial tendon. Non-MTUS Guidelines were cited. On 2/09/15, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Posterior Tibial Tendon Excision: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Center for Biotechnology Information's PubMed Database - (www.ncbi.nlm.nih.gov/pubmed)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375. Decision based on Non-MTUS Citation Ankle and Foot: Surgery for posterior tibial tendon ruptures

Decision rationale: The California MTUS 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. Repairs of ligament tears are generally reserved for chronic instability. The Official Disability Guidelines recommend surgery for posterior tibial tendon tears when conservative treatment fails. In the early stages, posterior tibial tendon dysfunction may be treated with rest, nonsteroidal anti-inflammatory drugs such as aspirin or ibuprofen, and immobilization of the foot for 6 to 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 for flatfoot deformities don't work, surgery may be necessary. Guideline criteria have not been fully met. This patient presents with a flatfoot deformity with tenderness over the posterior tibial tendon, tight Achilles tendon, and mild tenderness over the sinus tarsi. Pain reportedly limits ambulation tolerance to no more than one hour. There is reported imaging evidence of posterior tibialis tendinosis with possible intrasubstance tear, and minimal posterior tibialis tenosynovitis. There is no clinical exam evidence of instability. This patient has a body mass index over 50 with documented unstable diabetes that has previously precluded surgery. It has not been fully clarified that these issues have been adequately stabilized. Detailed evidence

of a recent, reasonable and/or comprehensive non-operative treatment protocol trial with patient compliance and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Calcaneal Lengthening Osteotomy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Center for Biotechnology Information's PubMed Database - (www.ncbi.nlm.nih.gov/pubmed)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375. Decision based on Non-MTUS Citation Ankle and Foot: Surgery for posterior tibial tendon ruptures

Decision rationale: The California MTUS 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. Repairs of ligament tears are generally reserved for chronic instability. The Official Disability Guidelines recommend surgery for posterior tibial tendon tears when conservative treatment fails. In the early stages, posterior tibial tendon dysfunction may be treated with rest, nonsteroidal anti-inflammatory drugs such as aspirin or ibuprofen, and immobilization of the foot for 6 to 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 for flatfoot deformities don't work, surgery may be necessary. Guideline criteria have not been fully met. This patient presents with a flatfoot deformity with tenderness over the posterior tibial tendon, tight Achilles tendon, and mild tenderness over the sinus tarsi. Pain reportedly limits ambulation tolerance to no more than one hour. There is reported imaging evidence of posterior tibialis tendinosis with possible intrasubstance tear, and minimal posterior tibialis tenosynovitis. There is no clinical exam evidence of instability. This patient has a body mass index over 50 with documented unstable diabetes that has previously precluded surgery. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial with patient compliance and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Calcaneal Medializing Osteotomy, Flexor Digitorum Longus Tendon to Posterior Tibial Tendon/Navicular Transfer: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Center for Biotechnology Information's PubMed Database - (www.ncbi.nlm.nih.gov/pubmed)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375. Decision based on Non-MTUS Citation Ankle and Foot: Surgery for posterior tibial tendon ruptures

Decision rationale: The California MTUS 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. Repairs of ligament tears are generally reserved for chronic instability. The Official Disability Guidelines recommend surgery for posterior tibial tendon tears when conservative treatment fails. In the early stages, posterior tibial tendon dysfunction may be treated with rest, nonsteroidal anti-inflammatory drugs such as aspirin or ibuprofen, and immobilization of the foot for 6 to 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 for flatfoot deformities don't work, surgery may be necessary. Guideline criteria have not been fully met. This patient presents with a flatfoot deformity with tenderness over the posterior tibial tendon, tight Achilles tendon, and mild tenderness over the sinus tarsi. Pain reportedly limits ambulation tolerance to no more than one hour. There is reported imaging evidence of posterior tibialis tendinosis with possible intrasubstance tear, and minimal posterior tibialis tenosynovitis. There is no clinical exam evidence of instability. This patient has a body mass index over 50 with documented unstable diabetes that has previously precluded surgery. It has not been fully clarified that these issues have been adequately stabilized. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial with patient compliance and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Iliac Crest Bone Graft Allograft: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Ankle & Foot, Allograft for Ankle Reconstruction

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ankle and foot: Allograft for ankle reconstruction

Decision rationale: The California MTUS guidelines do not provide recommendations relative to allograft use. The Official Disability Guidelines state that percutaneous lateral ligament reconstruction with allograft may be a useful method as a salvage procedure for the treatment of severe and complicated types of chronic lateral ankle instability. Criteria for the use of allograft include body mass index higher than 25. Guideline criteria have not been met as the associated procedure has not been found medically necessary. Therefore, this request is not medically necessary.

Percutaneous Tendoachilles Lengthening: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Center for Biotechnology Information's PubMed Database - (www.ncbi.nlm.nih.gov/pubmed)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375. Decision based on Non-MTUS Citation Ankle and Foot: Surgery for posterior tibial tendon ruptures

Decision rationale: The California MTUS 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. Repairs of ligament tears are generally reserved for chronic instability. The Official Disability Guidelines recommend surgery for posterior tibial tendon tears when conservative treatment fails. In the early stages, posterior tibial tendon dysfunction may be treated with rest, nonsteroidal anti-inflammatory drugs such as aspirin or ibuprofen, and immobilization of the foot for 6 to 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 for flatfoot deformities don't work, surgery may be necessary. Guideline criteria have not been fully met. This patient presents with a flatfoot deformity with tenderness over the posterior tibial tendon, tight Achilles tendon, and mild tenderness over the sinus tarsi. Pain reportedly limits ambulation tolerance to no more than one hour. There is reported imaging evidence of posterior tibialis tendinosis with possible intrasubstance tear, and minimal posterior tibialis tenosynovitis. There is no clinical exam evidence of instability. This patient has a body mass index over 50 with documented unstable diabetes that has previously precluded surgery. It has not been fully clarified that these issues have been adequately stabilized. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial with patient compliance and failure has not been submitted. Therefore, this request is not medically necessary at this time.

Excision of Sinus Tarsi Ganglion Cyst: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Ankle & Foot, Ganglion Cyst Removal

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ankle and foot: Ganglion cyst removal

Decision rationale: The California MTUS guidelines do not provide recommendations for ganglion cyst removal in ankle and foot conditions. The Official Disability Guidelines recommend surgical removal if the ganglion cyst is painful, the ganglion cyst is pushing directly on a nerve and can cause nerve damage, or the ganglion cyst is large enough that it makes it difficult to wear shoes. Guideline criteria have not been met. There is no documentation in the provided clinical or imaging records of a ganglion cyst. There is no current documentation relative to a painful ganglion cyst, nerve involvement, or size. Therefore, this request is not medically necessary.