MAXIMUS Federal Services

Case Number:	CM15-0055704		
Date Assigned:	04/01/2015	Date of Injury:	06/05/2010
Decision Date:	05/01/2015	UR Denial Date:	03/03/2015
Priority:	Standard	Application Received:	03/24/2015

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 who sustained an industrial injury on 6/5/10. Past surgical history was positive for right percutaneous plantar fascial release using Tenex percutaneous tenotomy and open tarsal tunnel release on 11/4/13. There was no improvement of symptoms following surgery. The 8/12/14 right ankle MR arthrogram impression documented an essentially normal for age right ankle MRI arthrogram. There was no convincing evidence of tarsal tunnel syndrome. There was some susceptibility artifact (possibly micro metallic) along the skin and subcutaneous tissues of the medial hindfoot raising the question of prior incision in this area. The osseous and cartilaginous, ligamentous, tendinous and tarsal tunnel were all reported as unremarkable. The 2/12/15 orthopedic consult report cited constant moderate to severe right foot pain. Pain was located on top of the foot on the left side, and additional pain in the medial and lateral ankle. There was also swelling. Symptoms were aggravated by standing. Right ankle active and passive range of motion was dorsiflexion 0, plantar flexion 50, eversion 15, and inversion 35 degrees. First metatarsophalangeal extension was 70 degrees and flexion 45 degrees. Gait was normal. There was primary tenderness over the right plantar fascia insertion and secondary tenderness over the right anterior talofibular ligament. The diagnoses included calcaneofibular ankle sprain, equinus deformity of the foot, plantar fascial fibromatosis. The injured worker had reportedly failed conservative treatment, physical therapy, and bracing. She had ankle instability. The treatment plan recommended lateral ankle ligament repair with peroneus tendon autograft and ankle arthroscopy for decompression of impinging spurs, evaluation of loose bodies, and possible associated talar osteochondral dissecans; and tarsal

tunnel release, plantar fasciectomy and possible gastroc release. The 3/3/15 utilization review non-certified the request for lateral ankle ligament repair with peroneus tendon autograft and ankle arthroscopy for decompression of impinging spurs, evaluation of loose bodies and possible associated talar osteochondral desiccans, and a pre-operative visit. The 3/10/15 treating physician report appeal indicated that the patient had failed orthotics, physical therapy, bracing, anti-inflammatory, night splinting, and prior surgery. She had on-going instability and gastroc tightness. Surgery was recommended by a fellowship trained orthopedic surgeon. The injured worker was very optimistic about the surgery and would like to go forward so she could perform activities of daily living comfortably. Right ankle exam documented normal range of motion, and tenderness on the anterior, medial and lateral ankle and into the posterior tibial tendon. She can do a single toe rise. The diagnosis was right ankle pain, and status post Baxter's nerve release and percutaneous plantar fascial release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Lateral Ankle Ligament Repair with peroneus tendon autograft and ankle arthroscopy for decompression of impinging spurs, evaluation of loose bodies and possible associates talar ocd, stryer procedure (gastronemuis release), tarsal tunnel release, plantar fasciectomy and tenoglide: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Indications for Surgery; Arthroscopy of the Ankle; Surgery for Tarsal Tunnel syndrome; Surgery for plantar fasciitis.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374 and 375. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot: Surgery for tarsal tunnel syndrome; Lateral ligament ankle reconstruction (surgery).

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. Repairs of ligament tears are generally reserved for chronic instability. The Official Disability Guidelines (ODG) provides specific indications for lateral ligament ankle reconstruction surgery for chronic instability or ankle sprain/strain. Criteria include physical therapy (immobilization with support cast or brace and rehabilitation program). Subjective and objective clinical findings showing evidence of instability and positive anterior drawer are required. Imaging findings are required including positive stress x-rays identifying motion at the ankle or subtalar joint. The ODG recommend surgery for tarsal tunnel syndrome after conservative treatment for at least one month. Patients with clinical findings and positive electrodiagnostic studies of tarsal tunnel syndrome warrant surgery when significant symptoms do not respond to conservative management. Guideline criteria have not been met. This patient presents with chronic right ankle pain with functional difficulty in activities of daily living. She

is status post right percutaneous plantar fascial release using Tenex percutaneous tenotomy and open tarsal tunnel release. She has undergone extensive post-operative treatment including 20 visits of physical therapy, activity modification, orthotics, bracing, and anti-inflammatories without improvement. However, there are no clinical exam findings of instability or positive anterior drawer sign. There is no positive stress x-rays documented in the submitted records. Imaging was reported as normal with no evidence of tarsal tunnel syndrome or ligament/tendon instability. There is no electrodiagnostic evidence of tarsal tunnel syndrome. Therefore, this request is not medically necessary.

Pre-Operative Visit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92 and 93.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.