

Case Number:	CM14-0138981		
Date Assigned:	09/05/2014	Date of Injury:	02/21/2009
Decision Date:	10/24/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/27/2014

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 Podiatric Surgery and is licensed to practice in New York. 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:

According to the enclosed information, the original date of injury for this patient was 2/21/2009. It is noted that the patient sustained a right ankle sprain while at work. By the time she returned home her right ankle was swollen and painful. The patient eventually underwent x-ray evaluation and subsequently MRI evaluation of the right foot and ankle. During this time she worked full-time. She did receive physical therapy to the right foot and ankle. On 3/26/2014 this patient was evaluated by an orthopedic surgeon. Patient relates persistent pain to the right ankle even with the use of a brace. Three different MRIs are noted in this progress note, noting Peritendinitis of the Achilles tendon, a degenerative cyst in the posterior calcaneus, subchondral and osteochondral lesions of the talus, subchondral lesion of the posterior subtalar joint, and most recently a nondisplaced fracture of the calcaneus. Nerve conduction studies reveal prolonged latency of the posterior tibial tendon right side. Physical exam reveals pain upon palpation throughout most of the foot and ankle, especially at the subtalar joint with passive range of motion. No crepitus or gaps noted. Subtalar joint range of motion causes tenderness bilaterally. Muscle strength is within normal limits bilateral lower extremity muscle groups. Diagnoses this day includes right subtalar joint arthritis secondary to calcaneal fracture, osteochondral lesion at the talus seen on MRI. The physicians states that the patient's main area of tenderness is at the subtalar joint. He recommends a hinged AFO to allow ankle joint range of motion and reduce subtalar joint range of motion. Orthopedic shoes are also recommended to compensate for the height difference for the AFO.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral ankle foot orthosis (AFO) braces: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Orthotic Devices

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Guidelines (ODG) : occupational disorders of the ankle and foot, procedure summary ankle and foot

Decision rationale: After careful review of the enclosed information and the pertinent ODG guidelines for this case, the bilateral ankle and foot orthosis/braces is not medically reasonable or necessary according to the guidelines for this patient at this time. The ODG guidelines are very specific with regards to AFOs and braces. With regards to AFO's, the guidelines state that AFOs are recommended as an option for foot drop. An ankle foot orthosis (AFO) also is used during surgical or neurologic recovery. The specific purpose of an AFO is to provide toe dorsiflexion during the swing phase, medial and/or lateral stability at the ankle during stance, and, if necessary, push-off stimulation during the late stance phase. An AFO is helpful only if the foot can achieve plantigrade position when standing. Any equinus contracture prohibits its successful use. The most commonly used AFO in foot drop is constructed of polypropylene and inserts into a shoe. If it is trimmed to fit anterior to the malleoli, it provides rigid immobilization. This is used when ankle instability or spasticity is problematic, such as in patients with upper motor neuron diseases or stroke. If the AFO fits posterior to the malleoli (posterior leaf spring type), plantar flexion at heel strike is allowed, and push-off returns the foot to neutral for the swing phase. This provides dorsiflexion assistance in instances of flaccid or mild spastic equinovarus deformity. A shoe-clasp orthosis that attaches directly to the heel counter of the shoe also may be used. (Geboers, 2002) The guidelines go on to state that an Arizona brace, which is one of the more popular AFO type braces, is not recommended in the absence of a clearly unstable joint. There are no quality published studies specific to the Arizona Brace. This patient does not have a diagnosis of a foot drop, nor is she recovering from a surgical or neurologic deficit. It is also not documented that she suffers with an unstable subtalar joint. For these reasons she does not meet the necessary guidelines for coverage of an AFO brace.

Bilateral component to AFO brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Orthotic Devices

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG): occupational disorders of the ankle and foot, procedure summary ankle and foot

Decision rationale: After careful review of the enclosed information and the pertinent ODG guidelines for this case, the bilateral components for an ankle and foot orthosis/braces is not medically reasonable or necessary according to the guidelines for this patient at this time. The ODG guidelines are very specific with regards to AFOs and braces. With regards to AFO's, the

guidelines state that AFOs are recommended as an option for foot drop. An ankle foot orthosis (AFO) also is used during surgical or neurologic recovery. The specific purpose of an AFO is to provide toe dorsiflexion during the swing phase, medial and/or lateral stability at the ankle during stance, and, if necessary, push-off stimulation during the late stance phase. An AFO is helpful only if the foot can achieve plantigrade position when standing. Any equinus contracture prohibits its successful use. The most commonly used AFO in foot drop is constructed of polypropylene and inserts into a shoe. If it is trimmed to fit anterior to the malleoli, it provides rigid immobilization. This is used when ankle instability or spasticity is problematic, such as in patients with upper motor neuron diseases or stroke. If the AFO fits posterior to the malleoli (posterior leaf spring type), plantar flexion at heel strike is allowed, and push-off returns the foot to neutral for the swing phase. This provides dorsiflexion assistance in instances of flaccid or mild spastic equinovarus deformity. A shoe-clasp orthosis that attaches directly to the heel counter of the shoe also may be used. (Geboers, 2002) The guidelines go on to state that an Arizona brace, which is one of the more popular AFO type braces, is not recommended in the absence of a clearly unstable joint. There are no quality published studies specific to the Arizona Brace. This patient does not have a diagnosis of a foot drop, nor is she recovering from a surgical or neurologic deficit. It is also not documented that she suffers with an unstable subtalar joint. For these reasons she does not meet the necessary guidelines for coverage of an AFO brace. Therefore she would not require or meet the guidelines for components for an AFO brace.

Bilateral Orthopedic Footwear: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Orthotic Devices

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) occupational disorders of the ankle and foot, procedure summary ankle and foot

Decision rationale: After careful review of the enclosed information and the pertinent ODG guidelines for this case, it is my feeling that the decision for bilateral orthopedic footwear is not medically reasonable or necessary for this patient at this time according to the guidelines. It is clearly stated in the progress note from this patient's orthopedic surgeon that the orthopedic shoe gear is being dispensed to accommodate the AFO and the height difference that the AFO would cause for this patient. As noted above, this patient does not meet the coverage criteria for an AFO or AFO components. Because this patient does not meet the criteria for the AFO or AFO components, there is no reason for there to be dispensed a pair of orthopedic shoes to accommodate the AFO.