

<b>Case Number:</b>	CM15-0013781		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	02/21/2013
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2015

### 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: New York  
 Certification(s)/Specialty: Podiatrist

### 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 39 year old male, who sustained an industrial injury on 2/21/2013. He has reported pain in the foot limiting ability to ambulate. The diagnoses have included complex regional pain syndrome (CRPS) and plantar fasciitis. Treatment to date has included medication, decreased weight bearing, orthotics, and steroid injection. Currently, the Injured Worker complains of right foot pain and ankle pain. Physical examination from 10/2/14 documented positive tenderness to Achilles tendon area and bottom of right heel. Plan of care included continuation for medications as ordered and possible surgical intervention per podiatrist. An evaluation completed by podiatry on 10/22/14 significant for continues sural neuroma pain, difficulty with ambulation, Haglund's deformity, pain with palpation to heel. The diagnoses included Haglund's deformity right heel, plantar fasciitis, sural neuroma, and painful gait. The plan included Magnetic Resonance Imaging (MRI) for bone scan, psychological evaluation for depression, medications. On 1/9/2015 Utilization Review non-certified a of plantar fasciectomy of the right foot, post operative physical therapy three times a week for four weeks, knee walker and cam walker, hot/cold therapy and shower boot, noting the documentation did not support failure of conservative treatment. The MTUS and ODG Guidelines were cited. On 1/23/2015, the injured worker submitted an application for IMR for review of plantar fasciectomy of the right foot, post operative physical therapy three times a week for four weeks, knee walker and cam walker, hot/cold therapy and shower boot.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Plantar fasciectomy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ankle & Foot, Surgery for Plantar Fasciitis

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 a plantar fasciectomy is not medically reasonable or necessary for this patient at this time. According to the ODG guidelines, ankle and foot, page 44, surgery for plantar fasciitis is not recommended except in certain circumstances. It appears, after reading the enclosed progress notes and enclosed information, that this patient has not exhausted all conservative treatments. Furthermore, the MRI enclosed in this case does not advise of inflammation to the plantar fascia/plantar fasciitis. Tarsal syndrome has not ruled out as well. For these reasons, I do not feel that surgical intervention is warranted for this patient's heel pain at this time.

**Post Operative Physical Therapy 3 x 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 13.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Knee Walker: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guides (ODG), Knee & Leg, Walking Aids

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**CAM Walker: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Walking Aids

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Hot/Cold Therapy, IF Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain, Interferential (IF) Unit, ODG, Ankle & Foot, Cold Packs

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Shower Boot:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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