

<b>Case Number:</b>	CM15-0064551		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	03/10/2014
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	04/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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 44-year-old who sustained an industrial injury on 3/10/14. Injury occurred when a 150-pound container fell, landing on his right leg, knee and ankle. He underwent open reduction and internal fixation syndesmosis with reduction of ankle dislocation and closed treatment of proximal fibula fracture on 3/14/14. He subsequently underwent removal of deep hardware under local anesthesia on 9/26/14. The 11/24/14 right lower extremity CT scan impression documented a partially united proximal fibular shaft fracture, with small areas of discontinuity. There was approximately 4 mm of separation of the proximal fibular shaft from the remainder of the fibula. The 1/8/15 right ankle MRI impression documented bone infarct of the posterior and medial malleolus, post-operative changes related to reported history of syndesmosis fixation screw removal, and no discrete peroneal tendon pathology. The subtalar joints, talonavicular, calcaneocuboid, and visualized midfoot joint articulations are intact. The tibialis posterior, tibialis anterior, flexor, extensor, and peroneal tendons were unremarkable. The ligamentous structures were intact and there was no significant joint effusion. The 3/23/15 treating physician report cited constant throbbing right ankle and proximal leg pain, and ankle stiffness. Ankle movement increased the pain. He was working short hours at modified duty but walking in the fields increased the pain. He also reported persistent lower back pain. Physical exam documented no swelling, mild diffuse tenderness at the lateral and medial malleoli and anterior talofibular ligament, deltoid ligament and peroneus tendon. There was significantly limited and painful range of motion at the right ankle. There was mild tenderness at the lateral proximal leg at the proximal fibula. Gait was antalgic on the right in CAM boot. The diagnosis

was right ankle joint pain, tendinitis of the right peroneal tendon, and right lower leg pain. Conservative treatment had included podiatric evaluation, CAM boot immobilization, anti-inflammatory, activity modification, and physical therapy. The treatment plan included the request for right ankle arthroscopy, possible syndesmosis repair, and possible peroneal tendon repair. The injured worker was to continue at modified duty using the CAM boot. The 4/1/15 utilization review non-certified the request for right ankle arthroscopy, possible syndesmosis repair, and possible peroneal tendon repair. The rationale for non-certification noted that there were no stress films evaluating the syndesmosis, no discussion of intraarticular pathology to be addressed, and clinical findings were limited to pain.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right ankle arthroscopy, possible syndesmosis repair, possible peroneal tendon repair:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374, 376-377. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-ankle and foot chapter, indications for surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot: Diagnostic arthroscopy; Lateral ligament ankle reconstruction; Peroneal tendinitis/tendon rupture (treatment); Surgery for ankle sprains.

**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) recommend conservative treatment for peroneal tendinitis, and surgery as an option for a ruptured tendon. Patients with peroneal tendonitis, but no significant peroneal tendon tear, can usually be treated successfully non-operatively. In patients with a large peroneal tendon tear or a bony prominence that is serving as a physical irritant to the tendon, surgery may be beneficial. The ODG indications for lateral ligament reconstruction include physical therapy and immobilization with a brace or support cast, subjective complaints of instability and swelling, positive anterior drawer sign, and positive stress x-rays identifying motion at the ankle or subtalar joint. Guideline criteria have not been met. This injured worker presents with persistent right ankle and lower leg pain. Functional difficulty is noted in walking on uneven surfaces and with ankle motion. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there are no clinical exam findings or imaging evidence of right ankle instability. There is no documentation of positive stress x-rays showing motion at the ankle or subtalar joint. Therefore, this request is not medically necessary.