California Orthopaedic Association

Utilization Review Checklist

ACHILLES TENDON RUPTURE

This checklist is intended to help orthopaedic surgeons document important factors for utilization reviewers (UR) when determining the medical necessity for this procedure(s). The checklists, developed by members of COA's Workers' Compensation Committee, will help our members anticipate what questions Utilization Reviewers will need to have documented in order for them to make more informed decisions. COA cannot guarantee that if you document the below issues, the procedure(s) will be approved, but it should help clarify the conservative treatment that the injured worker may have received, the results of the diagnostic imaging tests, and why you believe surgery is indicated.

Please remember that medical treatment requests should be based on the DWC's Medical Treatment Utilization Schedule (MTUS) http://www.dir.ca.gov/dwc/mtus/mtus_regulationsguidelines.html whenever possible as the MTUS guidelines are presumed correct. If the procedure is not covered by MTUS, you are able to utilize other nationally-recognized treatment guidelines such as ACOEM or ODG. You can utilize other high quality guidelines to document medical necessity.

Attach the below checklist along with a copy of the research justifying the procedure to your Request for Authorization (RFA). Having a summary of care to date to add to the checklist facilitates approval.

WORKERS' COMPENSATION UTILIZATION REVIEW CHECK LIST

ACHILLES TENDON RUPTURE

Patient name: _____

Claim number: _____

	Check if present
MTUS – ACOEM Guidelines are not applicable to this case	
DIAGNOSIS	
Clinical history and examination (Thompson test)	
MRI	
Ultrasound	

Surgery for Treatment of Achilles Tendon Rupture

Recommended. Surgical repair is recommended for treatment of ruptured Achilles tendon. (The mixed results of the data supporting operative and non-operative care should be discussed with patients when covering treatment options. Discussion should include the numbers needed to treat or harm or likelihood that they will benefit from surgical care versus non-surgical care – 1 in 11, or be harmed by surgical care – 1 in 3), and the equivocal superiority of surgical compared to non-operative treatment.)

Strength of Evidence – **Recommended, Evidence (C)**
Level of Confidence – **Moderate**

Augmented Surgical Repair for Chronic or Neglected Ruptures

No Recommendation. There is no recommendation for or against the use of augmented repair for chronic or neglected ruptures.

Strength of Evidence – **No Recommendation, Insufficientt Evidence (I)**
Level of Confidence – **Low**

Rationale: There are two moderate-quality studies that compare open to a percutaneous approach for tenorrhaphy and both studies do not show clear evidence of superiority of one approach over the other.(132, 133) In a moderate- quality trial of 60 repaired tendons, there were no differences found in functional recovery, rerupture or time to return to sports.(132) However, there were more infections in the open repair group (21% versus 0%). In a second moderate-quality trial of 40 patients, equivocal results were again demonstrated between the two repair techniques, with no differences despite different post-operative

immobilization durations.(133) Thus, there is currently insufficient evidence to recommend one approach over the other, and both are recommended. Potential advantages for percutaneous repairs include shorter procedure time completed under local anesthesia without a tourniquet,(133) cosmetic results, and fewer wound complications. There is one moderate-quality study on suture technique of end-to-end repair which found no difference in a reinforced continuous 6-strand suture technique compared with a simple Mason technique.(134) Thus, there is no recommendation for any particular suture type or technique in end-to-end repairs.

There are two moderate-quality trials that compare open procedure end-to end suture techniques versus augmentation of repair using either a portion of the plantaris tendon or down-turned gastrocnemius fascia flap in patients with acute ruptures.(135, 136) From both trials, no additional advantages were gained from augmentation as measured by functional improvement or reruptures after long-term follow-up. Augmentation presumptively has higher risk of deep tissue infection, deep venous thrombosis, and delayed wound healing as the incision site may cross more poorly vascularized skin.(123, 124, 128) These two trials did not demonstrate significant differences in adverse outcomes. Functional deficits at the tendon donor site may also be of concern,(127, 137) although the trials did not demonstrate these deficits. There is no quality evidence for or against the use of augmentation in repairing chronic or neglected ruptures. Increased tensile strength over suture alone is reported in cadaveric studies.(138-140) Therefore, there is evidence that augmentation repair for acute injury tendon repair is not recommended due to lack of demonstrated benefit. There is insufficient evidence to recommend for or against using augmentation techniques for chronic or neglected ruptures, and there may be surgical situations in which the only option for repair is augmentation. Further studies regarding improvement of function, adverse effects including re-rupture rates, and donor site functional deficits are required.

Evidence: There are 5 moderate-quality RCTs or quasi-randomized controlled trials incorporated into this analysis.

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