

<b>Case Number:</b>	CM13-0019214		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	11/24/2010
<b>Decision Date:</b>	08/01/2014	<b>UR Denial Date:</b>	08/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2013

### 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 11/24/2010. While at work patient suffered a crush injury to the right foot. A laceration also occurred during this injury. On 4/19/2013 patient visited his podiatrist with complaints of continued heel pain, heel numbness, and ankle instability. Physical exam reveals painful heel, moderate edema, allodynia, stasis pigmentation, hyper anesthesia, and antalgic gait. Treatment today includes activity modification, medications, ORIF, physical therapy, foot braces, ultrasound, acupuncture, cortisone injections, and soft supports. On 7/3/2013 patient is still noted to have foot and ankle pain. Patient is noted to be working. Patient is noted to have pain to the anterior medial and posterior right heel. Numbness is also noted to these areas. Unstable gait with right foot weaknesses noted. On 7/31/2013 patient is still noted to have right foot and ankle pain. Physical exam reveals continued allodynia, dyesthesias, paresthesias involving the medial plantar right heel. A scar is noted in the calcaneal branch of the posterior tibial nerve. Functional instability of the ankle joint and subtalar joint is noted right side. Physical exam also reveals the beginning of foot drop with a toe catch upon ambulation. Prior treatment has helped a bit however is not alleviated all of the patient's pain. Immobilization, racing, cortisone injections, pain medication, racing, taping, and custom orthotics foot braces have all been attempted to treat patients right foot pain. Decreased superficial sensory reflexes are noted with allodynia and a positive Tinel's sign to the right foot.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient Surgery to Include Percutaneous Decompression Along With Prev Entrapment Neuritis, Scar Area Right Heel, Calcaneal And Calcaneal Branch Of Posterior Tibial Nerve**  
**R: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374-375. Decision based on Non-MTUS Citation Clinical Orthopedics: Treatment of chronic heel pain by surgical release of the first branch of the lateral plantar nerve, pg. 229-236.

**Decision rationale:** After careful review of the enclosed information and the MTUS guidelines pertinent for this case, chapter 14 of the MTUS states that referral for surgical consultation may be indicated for patients who have activity limitation for more than one month without signs of functional improvement, failure of exercise programs to increase range of motion and strength of the musculature around the ankle and foot, clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. According to progress notes, there is no imaging evidence of the lesion to this patient's right ankle that has been shown to benefit in the both short and long-term from surgical repair. According to table 14 - 6 of chapter 14 MTUS guidelines, surgical repair of bunions, Morton neuroma excision, and lateral ankle instability surgical repair is recommended. It is quiet on any other surgery. Finally, percutaneous decompression is recommended by this physician for this patient. Current medical literature does not support the need for percutaneous decompression of the lateral calcaneal nerve. It does however support open surgical release of the lateral calcaneal and or posterior tibial nerve. This is noted in numerous textbooks on orthopedics and podiatry as well as numerous medical research articles.

**Custom AFO:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 376. Decision based on Non-MTUS Citation ODG, Ankle and Foot Bracing.

**Decision rationale:** After careful review of the enclosed information and the MTUS guidelines pertinent in this case, it is my feeling that the decision for a custom AFO is reasonable and medically necessary for this patient. The guidelines state that braces and supports are recommended in the management of injuries to the ankle and foot. The ODG guidelines state that ankle foot orthoses are recommended as an option for foot drop. It is noted in the progress note that this patient does suffer with a foot drop and a toe catch.

**Nerve Block Times 1 For Diagnostic and Therapeutic purposes:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nerve Blocks And Trigger Point Injections Page(s): 55,122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter on pain.

**Decision rationale:** After careful review of the enclosed information and the pertinent guidelines for this case, it is my feeling that the decision for nerve block x 1 for diagnostic and therapeutic purposes is not medically reasonable or necessary at this time. The Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain, symptoms have persisted for more than three months, medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present, not more than 3-4 injections per session, no repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement. frequency should not be at an interval less than two months, trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. This patient, according to the enclosed documentation, is not suffering with myofascial pain syndrome and does not meet the criteria for a local anesthetic trigger point injection. Furthermore, nerve blocks are not recommended according to the below criteria. Not recommended, except as indicated below when other treatments are contraindicated. For detailed recommendations by type of block, see Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block). One meta-analysis found that no significant difference was found between guanethidine and placebo on any of the outcome measures and in one case the trial was stopped prematurely because of the severity of the adverse effects. Another randomized controlled trial of 32 patients found that IVclodronate is better than placebo and induces lasting improvement of RSD/CRPS. A randomized controlled trial using guanethidine found that guanethidine was no better than the placebo in improving pain scores in RSD/CRPS. (Ramamurthy, 1995) Since there is a trial suggesting benefit from intravenous regional sympathetic blocks, while not recommended, if other treatments are contraindicated (e.g. when a stellate ganglion block cannot be done due to bleeding diathesis), intravenous regional blocks may be performed.