Case Number:	CM14-0174989		
Date Assigned:	10/28/2014	**Date of Injury:**	06/03/2000
Decision Date:	12/04/2014	**UR Denial Date:**	09/26/2014
Priority:	Standard	**Application Received:**	10/22/2014

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 Internal Medicine 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:

The patient is a 64 year old male with a date of injury of 06/03/2000. In 2008 he had left peroneal lateral ankle tendon repair. On 06/26/2014 the patient had low back, left knee and left ankle pain. The diagnosis was lumbar spondylolisthesis, left medial meniscus tear, and left ankle lateral ligament tear. On 08/26/2014 he had low back spasm/pain, left ankle pain and left knee pain. Lumbar range of motion was decreased. McMurrak's sing was present at the left knee. There was left quadriceps atrophy. Range of motion was from 0 to 110 degrees. There was tenderness of the fifth metatarsal and lateral ankle. Ankle instability was noted. Again the diagnosis was lumbar spondylolisthesis, left knee medial meniscus teat and left ankle lateral ligament tear. There was no primary foot disorder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral foot custom orthotics: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 2014, Ankle and Foot, Orthotic Devices

Decision rationale: MTUS ACOEM does not mention custom foot orthotics. Official Disability Guidelines 2014 Ankle and Foot section on orthotic devices notes: "Recommended for plantar fasciitis and for foot pain in rheumatoid arthritis. See also Prostheses (artificial limb). Both prefabricated and custom orthotic devices are recommended for plantar heel pain (plantar fasciitis, plantar fasciosis, heel spur syndrome). (Thomas, 2010) Orthoses should be cautiously prescribed in treating plantar heel pain for those patients who stand for long periods; stretching exercises and heel pads are associated with better outcomes than custom made orthoses in people who stand for more than eight hours per day. (Crawford, 2003) As part of the initial treatment of proximal plantar fasciitis, when used in conjunction with a stretching program, a prefabricated shoe insert is more likely to produce improvement in symptoms than a custom polypropylene orthotic device or stretching alone. The percentages improved in each group were: (1) silicone insert, 95%; (2) rubber insert, 88%; (3) felt insert, 81%; (4) Achilles tendon and plantar fascia stretching only, 72%; and (5) custom orthosis, 68%. (Pfeffer, 1999) Evidence indicates mechanical treatment with taping and orthoses to be more effective than either anti-inflammatory or accommodative modalities in the treatment of plantar fasciitis. (Lynch, 1998) (Gross, 2002) For ankle sprains, the use of an elastic bandage has fewer complications than taping but appears to be associated with a slower return to work, and more reported instability than a semi-rigid ankle support. Lace-up ankle support appears effective in reducing swelling in the short-term compared with semi-rigid ankle support, elastic bandage and tape. (Kerkhoffs, 2002) For hallux valgus the evidence suggests that orthoses and night splints do not appear to be any more beneficial in improving outcomes than no treatment. (Ferrari-Cochrane, 2004) Semirigid foot orthotics appear to be more effective than supportive shoes worn alone or worn with soft orthoses for metatarsalgia. (Chalmers, 2000) The use of shock absorbing inserts in footwear probably reduces the incidence of stress fractures. There is insufficient evidence to determine the best design of such inserts but comfort and tolerability should be considered. Rehabilitation after tibial stress fracture may be aided by the use of pneumatic bracing but more evidence is required to confirm this. (Rome-Cochrane, 2005) Foot orthoses produce small short-term benefits in function and may also produce small reductions in pain for people with plantar fasciitis, but they do not have long-term beneficial effects compared with a sham device. The customized and prefabricated orthoses used in this trial have similar effectiveness in the treatment of plantar fasciitis. (Landorf, 2006) Eleven trials involving 1332 participants were included in this meta-analysis: five trials evaluated custom-made foot orthoses for plantar fasciitis (691 participants); three for foot pain in rheumatoid arthritis (231 participants); and one for hallux valgus (209 participants). Custom-made foot orthoses were effective for rearfoot pain in rheumatoid arthritis (NNT:4) and painful hallux valgus (NNT:6); however, surgery was even more effective for hallux valgus. It is unclear if custom-made foot orthoses were effective for plantar fasciitis or metatarsophalangeal joint pain in rheumatoid arthritis. (Hawke, 2008) Rocker profile shoes are commonly prescribed based on theoretical considerations with minimal scientific study and validation. Rocker profiles are used to afford pressure relief for the plantar surface of the foot, to limit the need for sagittal plane motion in the joints of the foot and to alter gait kinetics and kinematics in proximal joints. In this review, efficacy has not been demonstrated. The effectiveness of rocker-soled shoes in restricting sagittal plane motion in individual joints of the foot is unclear. Rocker profiles have minimal effect on the kinetics and kinematics of the more proximal joints of the lower limb, but more significant effects are seen at the ankle. (Hutchins, 2009) According to this systematic review of treatment for ankle sprains, pneumatic braces provide beneficial ankle support and may prevent subsequent sprains during high-risk sporting

activity. (Seah, 2011) Outcomes from using a custom orthosis are highly variable and dependent on the skill of the fabricator and the material used. A trial of a prefabricated orthosis is recommended in the acute phase, but due to diverse anatomical differences many patients will require a custom orthosis for long-term pain control. A pre-fab orthosis may be made of softer material more appropriate in the acute phase, but it may break down with use whereas a custom semi-rigid orthosis may work better over the long term. " There is no documentation of plantar fasciitis or heel spur. There was no reason provided for the custom orthotic request. There was no documentation of any primary foot issue. Custom orthotics is not used to treat a torn knee meniscus or a torn ankle ligament. Therefore, this request is not medically necessary.