MAXIMUS Federal Services

Case Number:	CM15-0147550		
Date Assigned:	08/10/2015	Date of Injury:	08/28/2013
Decision Date:	09/04/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	07/29/2015

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: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 48-year-old female, who sustained an industrial injury on August 28, 2013. She reported left knee pain. The injured worker was diagnosed as having left knee contusion and strain. She injured her right foot during the post-operative phase of a left knee surgery, and was diagnosed with a right foot fracture. Treatment to date has included x-rays, physical therapy (knee), knee surgery, knee injection and toxicology screen. Currently, the injured worker complains of left foot pain that is rated at 2 on 10 with medication, 4-5 on 10 with attempted repetitive weight-bearing activities and 7-8 on 10 without medication. The injured worker is diagnosed with a traumatic neuroma. Her work status is total temporary disability. The injured worker has received therapeutic benefit for her knee from an injection, per notes dated November 18, 2013. A physical therapy note dated June 30, 2015 states the injured worker requires continued physical therapy as she continues with decreased range of motion and strength. The following, one pair of extra depth shoes (to accommodate enlarged foot, hammer digits and orthotics) and three cortisone injections into the right third web-space (64450x3) (for pain relief) are requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Pair of Extra Depth Shoes: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 365-370. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot, Orthotics, shoes, heel pads Knee, Footwear, knee arthritis.

Decision rationale: ODG states" Recommended as an option for plantar fasciitis, but not for Achilles tendonitis". ACOEM recommends inserts for planta faciitis. ODG states "Recommended for plantar fasciitis and for foot pain in rheumatoid arthritis". ODG further states "Recommended as an option for patients with knee osteoarthritis. Recommend thin-soled flat walking shoes (or even flip-flops or walking barefoot). Recommend lateral wedge insoles in mild OA but not advanced stages of OA. Specialized footwear can effectively reduce joint loads in subjects with knee osteoarthritis, compared with self-chosen shoes and control walking shoes. This study compared the effects of a specialized shoe designed to lower dynamic loads at the knee (referred to as the mobility shoe, a flexible, lightweight shoe engineered to incorporate the potential biomechanic advantages of barefoot walking). The mobility shoe does not contain lifts at the heel, which have been shown to increase knee loads, and its flexible sole is designed to mimic the flexible movement of a bare foot. The results showed that the mobility shoes effectively reduced knee loads while walking. Most studies of wedge orthotics that are inserted into shoes have shown a five to eight percent reduction in load, while the present study showed eight to 13 percent reduction in load with the mobility shoes. (Shakoor, 2008) Insoles and footwear offer great potential, as simple, inexpensive-treatment strategies for knee osteoarthritis. Walking in shoes increases joint load compared with walking in bare feet. Shoes with a flat or low heel and that are flexible rather than stabilizing may be optimal; however, effects of off-the-shelf shoes on osteoarthritis symptoms are unknown. Promising shoe modifications include shoes that promote foot mobility and those with variable stiffness or laterally wedged soles. (Hinman, 2009) This study concluded that the Apos Therapy system and treatment methodology (a biomechanical device comprised of a foot-worn platform attached under the hind foot and forefoot regions, calibrated to the individual patient) is an effective non-pharmacological therapy that improves both pain and function in patients with knee OA. (Bar-Ziv, 2010) The knee adduction moment has an integral role in the development and progression of knee OA. A number of conservative biomechanics-based interventions can reduce the knee adduction moment effectively via different mechanisms. Many of these conservative biomechanical strategies can be employed in early stage OA and might help to prevent and/or delay disease progression. Wearing inappropriate footwear is linked with the development and progression of medial knee OA. In healthy women, high-heeled shoes increase the knee adduction moment by 18-23% and reduce the ankle eversion moment by 75% compared with barefoot walking, and walking barefoot reduces peak knee adduction moments in patients with medial knee OA by 7-13% compared with walking in normal shoes or in thick-soled shoes that offer stability and support. Although barefoot walking could reduce the knee adduction moment, thereby potentially influencing the progression of OA, the implications are that shoes that mimic the barefoot movement might be a more clinically relevant alternative. Peak knee adduction moments while walking barefoot were similar to those measured in patients wearing flat walking shoes and flip-flops. Thin-soled, flexible shoes seem to be beneficial for reducing knee joint loads compared with shoes with thicker soles. Lateral wedge insoles (a wedge inclined along the outside of the foot) reduce the knee adduction moment during walking. In patients with OA, the use of lateral wedge insoles of between 5 and 15 inclination reduce peak knee adduction moments by between 4% and 14% during walking compared with the corresponding values

either without insoles or wearing even-thickness control insoles and also led to immediate reductions in pain during walking. Extension of the lateral wedge along the entire length of the foot is important, since the knee, adduction moment is only reduced with a full-length insole, not with a lateral wedge covering just the heel region. Lateral wedge insoles reduce knee adduction moments in patients with early to mild OA (Kellgren/Lawrence grades 1-2), but not in patients with moderate-to-severe OA (grades 3-4) and these insoles were ineffective in patients with the most advanced stages of OA. Considering their immediate positive influence on the knee adduction moment and clinical utility, lateral wedge insoles should be considered as a potentially useful intervention, especially for patients with early OA. (Reeves, 2011) An inexpensive pair of flat shoes reduces joint loading during stair descent, similar to the barefoot condition, compared with heeled shoes, in women with knee osteoarthritis. (Sacco, 2011)" MTUS is silent regarding shoes. The medical documentation provided indicate this patient qualifies and has received approval for motion-control orthotics with top covers, it is reasonable to request a shoe that will accommodate these inserts. As such, the request for 1 Pair of Extra Depth Shoes is medically necessary.

3 Cortisone Injections into The Right Third Webspace (64450x3): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot (Acute & Chronic), Injections (corticosteroid).

Decision rationale: MTUS states "Invasive techniques (e.g., needle acupuncture and injection procedures) have no proven value, with the exception of corticosteroid injection into the affected web space in patients with Morton's neuroma or into the affected area in patients with plantar fasciitis or heel spur if four to six weeks of conservative therapy is ineffective." ODG states "Not recommended for tendonitis or Morton's Neuroma, and not recommend intra-articular corticosteroids. Under study for heel pain. See specific indications below." Heel pain (plantar fasciitis): Under study. There is no evidence for the effectiveness of injected corticosteroid therapy for reducing plantar heel pain. (Crawford, 2000) Steroid injections are a popular method of treating the condition but only seem to be useful in the short term and only to a small degree. (Crawford, 2003) Corticosteroid injection is more efficacious and multiple times more cost-effective than ESWT in the treatment of plantar fasciopathy. (Porter, 2005) This RCT concluded that a single ultrasound guided dexamethasone injection provides greater pain relief than placebo at four weeks and reduces abnormal swelling of the plantar fascia for up to three months, but significant pain relief did not continue beyond four weeks. (McMillan, 2012) Tendon (Achilles tendonitis): Not recommended. Cortisone injections in the area of the Achilles tendon are controversial because cortisone injected around the tendon is harmful and can lead to Achilles tendon ruptures. Local glucocorticoid injections have generated controversy for Achilles tendinopathy. This systematic review found little evidence to support their efficacy, and, furthermore, local glucocorticoid injections were associated with rupture of the Achilles tendon. Therefore, further research is required before glucocorticoid injections can be recommended for use in Achilles tendinopathy. (Metcalfe, 2009) The literature surrounding injectable treatments for Achilles tendinosis has inconclusive evidence concerning indications for treatment and the mechanism of their effects. Prospective studies are necessary to guide Achilles tendinosis treatment recommendations using injectable therapies. (Gross, 2013) There is little information available from trials to support the use of peritendonous steroid injection in the treatment of acute or chronic Achilles tendinitis. (McLauchlan, 2000) Achilles tendon corticosteroid

injections have been implicated in achilles tendon ruptures. (Coombes, 2010) Morton's Neuroma: Not recommend corticosteroid injections. There are no RCTs to support corticosteroid injections in the treatment of Morton's Neuroma. (Thomson, 2004) Alcohol injection of Morton's neuroma has a high success rate and is well tolerated. The results are at least comparable to surgery, but alcohol injection is associated with less morbidity and surgical management may be reserved for non-responders. (Hughes, 2007) Intra-articular corticosteroids: Not recommended. Most evidence for the efficacy of intra-articular corticosteroids is confined to the knee, with few studies considering the joints of the foot and ankle. No independent clinical factors were identified that could predict a better post-injection response. (Ward, 2008) Evidence is limited. (Colorado, 2001) See also Alcohol injections (for Morton's neuroma); Hyaluronic acid injections; Autologous blood-derived injections; Platelet-rich plasma (PRP)." MTUS recommends injections for neuromas, however additional cortisone injections be approved based on functional improvement and pain relief from previous injections. Previous reviewer modified this request to 1 cortisone injection. As such, the request for 3 Cortisone Injections into The Right Third Webspace (64450x3) is not medically necessary.