MAXIMUS Federal Services

Case Number:	CM15-0195028		
Date Assigned:	10/08/2015	Date of Injury:	01/18/2007
Decision Date:	11/24/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	10/05/2015

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: California, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

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 53 year old female, who sustained an industrial injury on January 18, 2007. The initial symptoms reported by the injured worker are unknown. The injured worker was diagnosed as having right tibia-fibula fracture and right foot nodule. Treatment to date has included medication, diagnostic studies and physical therapy. On August 13, 2015, the injured worker reported improvement and no complaints of pain. Physical examination revealed a right foot plantar 2cm painful nodule. Some of the handwritten progress report was illegible. The treatment plan included Kenalog injection to right foot, weight bearing as tolerated, medication, hold off on surgery and follow up visit. On September 1, 2015, utilization review denied a request for four units of Kenalog injection to right foot, injection materials, intramuscular route.

IMR ISSUES, DECISIONS AND RATIONALES

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

below: **4 units of Kenalog injection right foot, injection materials, intramuscular route:**

Upheld **Claims Administrator guideline:** Decision based on MTUS Ankle and Foot

Complaints 2004.

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

Decision rationale: Per the ODG guidelines regarding corticosteroid injections: 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 nonresponders. (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) The documentation submitted for review contained no rationale for the requested injection. Furthermore, there is no evidence supporting the requested injection is NOT medically necessary.