

<b>Case Number:</b>	CM15-0200141		
<b>Date Assigned:</b>	10/15/2015	<b>Date of Injury:</b>	03/03/2015
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/12/2015

### 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, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 46 year old female, who sustained an industrial injury on March 3, 2015. She reported immediate pain to her left ankle and leg. The injured worker was diagnosed as having instigation of symptomatic left talotibial osteoarthritis left ankle, osteochondral injury medial talar dome left ankle, synovitis and tenosynovitis posterior tibialis left ankle and rule out tarsal tunnel syndrome. Treatment to date has included diagnostic studies, medication and physical therapy. On August 5, 2015, the injured worker complained of unpredictable pain increasing when at rest or walking. Notes stated that she had "some improvement" with physical therapy. Physical examination of the left ankle revealed mild swelling and tenderness to palpation. The treatment plan included cortisone injection to left ankle (as requested on 06-30-2015) and a follow-up visit. On September 18, 2015, utilization review denied a request for cortisone injection left ankle peroneal tendon sheath.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cortisone Injection Left Ankle Peroneal Tendon Sheath:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Physical Methods.

**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 / peroneal tendonitis / tendon rupture (treatment).

**Decision rationale:** Per ODG ankle & foot / peroneal tendonitis / tendon rupture (treatment): "Recommend conservative treatment for tendinitis, and surgery as an option for a ruptured tendon. Patients with peroneal tendonitis, but no significant peroneal tendon tear, can usually be treated successfully non-operatively. In patients with a large peroneal tendon tear or a bony prominence that is serving as a physical irritant to the tendon, surgery may be beneficial. Peroneal tendonitis is an irritation to the tendons that run past the back outside part of the ankle, and it is a common cause of lateral ankle pain. Commonly it is an overuse condition that responds to conservative treatment, but if it is left untreated it can progress to a complete tendon rupture. Predisposing factors for peroneal tendonitis and rupture include varus alignment of the hindfoot and peroneal subluxation and dislocation. Participation in certain sports, including downhill skiing, skating, ballet, running and soccer creates higher risk for peroneal tendon tears. If caught early, peroneal tendonitis or instability may be treated conservatively with NSAIDs, immobilization and avoidance of exacerbating activities. Once secondary changes in the tendon occur, however, surgical treatment often becomes necessary. Surgery is indicated in the acute phase for peroneus brevis tendon rupture, acute dislocation, anomalous peroneal brevis muscle hypertrophy, and in peroneus longus tears that are associated with diminished function." In this case review of the medical records from 6/30/15 shows no failure of non-operative treatment to include NSAIDs, immobilization and avoidance of exacerbating activities. As this patient has not met ODG guidelines for further invasive treatment, the proposed injection is not medically necessary and the recommendation is not medically necessary.