

Case Number:	CM15-0221225		
Date Assigned:	11/16/2015	Date of Injury:	09/01/2001
Decision Date:	12/30/2015	UR Denial Date:	10/16/2015
Priority:	Standard	Application Received:	11/10/2015

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:

This is a 63 year old female with a date of injury on 9-1-01. A review of the medical records indicates that the injured worker is undergoing treatment for left foot pain and bilateral knee pain. Progress report dated 9-8-15 reports continued complaints of left knee pain. She had 4 left knee surgeries and 2 right knee surgeries. She reports recurrent palpable nodule in her left plantar foot. She had surgery to release the nodule. It went away and is now growing back and she can feel it when she walks. She also reports morning stiffness and post static dyskinesia and is well controlled with her shoes and orthotics. Objective findings: pain in the medial calcaneal tubercle bilaterally, diminished to absent sensation along the distribution of the medial plantar nerve, and palpable mass left foot. Treatments include: medication, extra deep shoes, custom foot orthotics, and surgery. Request for authorization dated 9-17-15 was made for Cortisone injections x 3 for the left foot. Utilization review dated 10-15-15 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cortisone injections x 3 for the left foot: 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. (Metcalf, 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 peritendinous 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 postinjection response. (Ward, 2008) Evidence is limited. (Colorado, 2001) As there is no evidence supporting the requested injection, medical necessity cannot be affirmed. Therefore, the requested treatment is not medically necessary.