

<b>Case Number:</b>	CM15-0058869		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	02/01/2012
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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: New Jersey, Michigan, California

Certification(s)/Specialty: Neurology, Neuromuscular 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 36 year old male, who sustained an industrial injury on February 1, 2012. He reported significant bilateral lower extremity weakness along with instability, left worse than right, difficulty ambulating, bilateral ankle pain and low back pain with radiating pain to the bilateral lower extremities. The injured worker was diagnosed as having ankle sprain/strain, gait abnormality, Achilles tendinitis, peroneal tendinitis, Pes planovalgus, ankle instability, bursitis, capsulitis, left greater than right and pain left greater than right. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention of the low back, physical therapy, a cane for ambulation, Unna's boot, medications and work restrictions. Currently, the injured worker complains of significant bilateral lower extremity weakness along with instability, left worse than right, difficulty ambulating, bilateral ankle pain and low back pain with radiating pain to the bilateral lower extremities. The injured worker reported an industrial injury in 2012, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on November 15, 2013, revealed pain as noted. It was noted no injections for the ankle would be ordered unless medication therapy failed. Evaluation on June 13, 2014, revealed continued pain as noted. Bilateral ankle injection with ultrasound guidance was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Bilateral ankle injection with ultrasound guidance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Injections (corticosteroid) <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, ankle injection is not recommended for tendonitis or Morton's Neuroma, and not recommended 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 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). Although ODG guidelines support ankle steroid injection in case of plantar fasciitis, there is no documentation that the patient is suffering from a plantar fasciitis. The patient was diagnosed with ankle sprain and tendinitis, which are not indications

for ankle injection. Therefore, the request for bilateral ankle injection with ultrasound guidance is not medically necessary.