

<b>Case Number:</b>	CM15-0117889		
<b>Date Assigned:</b>	06/26/2015	<b>Date of Injury:</b>	11/18/2014
<b>Decision Date:</b>	07/27/2015	<b>UR Denial Date:</b>	05/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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, Alabama, 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 47-year-old male, who sustained an industrial/work injury on 11/18/14. He reported initial complaints of right foot pain. The injured worker was diagnosed as having plantar fasciitis and metatarsalgia; tendinitis of right Achilles tendon. Treatment to date has included medication, cortisone injection, orthotics, modified activity, and physical therapy. X-Rays results were reported on 12/15/14 of the right ankle that reported no fracture or dislocation. Spurring can be seen of the posterior and inferior calcaneus. Currently, the injured worker complains of right foot pain that is improved with use of orthotic and a request was made for a second pair for use in another pair of shoes (work and home shoes). Per the primary physician's progress report (PR-2) on 5/6/15, examination reveals that the heel is less tender, no tenderness in the left heel, the foot orthoses are in good repair, and the patient shows an improvement in gait pattern. The requested treatments include second pair of orthotics.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**2nd pair of orthotics QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371.

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

**Decision rationale:** According to ODG guidelines, Orthotic devices "Recommended for plantar fasciitis and for foot pain in rheumatoid arthritis. See also Prostheses (artificial limb). Both prefabricated and custom orthotic devices are recommended for plantar heel pain (plantar fasciitis, plantar fasciosis, heel spur syndrome). (Thomas, 2010) Orthoses should be cautiously prescribed in treating plantar heel pain for those patients who stand for long periods; stretching exercises and heel pads are associated with better outcomes than custom made orthoses in people who stand for more than eight hours per day. (Crawford, 2003) As part of the initial treatment of proximal plantar fasciitis, when used in conjunction with a stretching program, a prefabricated shoe insert is more likely to produce improvement in symptoms than a custom polypropylene orthotic device or stretching alone. The percentages improved in each group were: (1) silicone insert, 95%; (2) rubber insert, 88%; (3) felt insert, 81%; (4) Achilles tendon and plantar fascia stretching only, 72%; and (5) custom orthosis, 68%. (Pfeffer, 1999) Evidence indicates mechanical treatment with taping and orthoses to be more effective than either anti-inflammatory or accommodative modalities in the treatment of plantar fasciitis. (Lynch, 1998) (Gross, 2002) For ankle sprains, the use of an elastic bandage has fewer complications than taping but appears to be associated with a slower return to work, and more reported instability than a semi-rigid ankle support. Lace-up ankle support appears effective in reducing swelling in the short-term compared with semi-rigid ankle support, elastic bandage and tape. (Kerkhoffs, 2002) For hallux valgus the evidence suggests that orthoses and night splints do not appear to be any more beneficial in improving outcomes than no treatment. (Ferrari-Cochrane, 2004) Semirigid foot orthotics appears to be more effective than supportive shoes worn alone or worn with soft orthoses for metatarsalgia. (Chalmers, 2000) The use of shock absorbing inserts in footwear probably reduces the incidence of stress fractures. There is insufficient evidence to determine the best design of such inserts but comfort and tolerability should be considered. Rehabilitation after tibial stress fracture may be aided by the use of pneumatic bracing but more evidence is required to confirm this. (Rome-Cochrane, 2005) Foot orthoses produce small short-term benefits in function and may produce small reductions in pain for people with plantar fasciitis, but they do not have long-term beneficial effects compared with a sham device. The customized and prefabricated orthoses used in this trial have similar effectiveness in the treatment of plantar fasciitis. (Landorf, 2006) Eleven trials involving 1332 participants were included in this meta-analysis: five trials evaluated custom-made foot orthoses for plantar fasciitis (691 participants); three for foot pain in rheumatoid arthritis (231 participants); and one for hallux valgus (209 participants). Custom-made foot orthoses were effective for rearfoot pain in rheumatoid arthritis (NNT:4) and painful hallux valgus (NNT:6); however, surgery was even more effective for hallux valgus. It is unclear if custom-made foot orthoses were effective for plantar fasciitis or metatarsophalangeal joint pain in rheumatoid arthritis. (Hawke, 2008) Rocker profile shoes are commonly prescribed based on theoretical considerations with minimal scientific study and validation. Rocker profiles are used to afford pressure relief for the plantar surface of the foot, to limit the need for sagittal plane motion in the joints of the foot and to alter gait kinetics and kinematics in proximal joints. In this review, efficacy has not been demonstrated. The effectiveness of rocker-soled shoes in restricting sagittal plane motion in individual joints of the foot is unclear. Rocker profiles have minimal effect on the kinetics and kinematics of the more proximal joints of the lower limb, but effects that are more significant are seen at the ankle.

(Hutchins, 2009) According to this systematic review of treatment for ankle sprains, pneumatic braces provide beneficial ankle support and may prevent subsequent sprains during high-risk sporting activity. (Seah, 2011) In reducing the risk of plantar fasciitis at work, the use of shoe orthoses with a medial longitudinal arch and metatarsal pad may be used as a preventive or treatment strategy. (Werner, 2010) Outcomes from using a custom orthosis are highly variable and dependent on the skill of the fabricator and the material used. A trial of a prefabricated orthosis is recommended in the acute phase, but due to diverse anatomical differences, many patients will require a custom orthosis for long-term pain control. A pre-fab orthosis may be made of softer material more appropriate in the acute phase, but it may break down with use whereas a custom semi-rigid orthosis may work better over the long term. See also Ankle foot orthosis (AFO). Bilateral orthotics: Bilateral foot orthotics/orthoses are not recommended to treat unilateral ankle-foot problems. (Song, 2009) See Limb length temporary adjustment device, where a heel/sole lift is recommended when it is necessary to balance the limb lengths from use of an orthotic device that will add more than 2 cm length to one lower extremity for a long duration". A second pair of orthotics in this context will be considered a convenience item. Therefore, the request for second pair of orthotics is not medically necessary.