

<b>Case Number:</b>	CM15-0118350		
<b>Date Assigned:</b>	06/26/2015	<b>Date of Injury:</b>	03/16/2009
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	06/09/2015
<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 54 year old male, who sustained an industrial injury on 3/16/09. He reported initial complaints of left foot/heel injury. The injured worker was diagnosed as having osteomyelitis left foot/heel; neuroma left foot; foot pain; spasm of muscle. Treatment to date has included status post left foot osteomyelitis os calcis with causalgia secondary to surgery resulting in neuromata of the medial calcaneal nerve surgery ( 5/9/09; 11/18/09 and 7/21/10); spinal cord stimulator trial (1/20/11); permanent spinal cord stimulator placement (3/2011); lumbar epidural steroid injection (1/15/14). Diagnostics included MRI left ankle (12/21/10; MRI left knee (10/20/10); MRI lumbar spine (11/21/13; 6/15/15). Currently, the PR-2 notes dated 5/21/15 indicated the injured worker was seen at this office as a period office visit. He rates his pain with medications as 8/10 and without medications 10/10. His quality of sleep is reported as poor. His current medications are Promethazine 25mg once daily PRN; Norco 10/325mg three times daily PRN and Skelaxin 800mg twice daily PRN. Objective findings note he has an antalgic gait that is slow and wide-based and is assisted by a cane. A physical examination of the lumbar spine is documented. The left ankle notes tenderness over the medial ankle, medial and lateral malleolus. His left foot reveals swelling and surgical scar medially. His range of motion is normal in inversion, eversion, flexion and extension at all the joints of the right foot. Movements are painful with inversion beyond 5 degrees and eversion beyond 5 degrees. Tenderness to palpation is noted over the heel, midfoot and positive allodynia along the L5. He is wearing a Bledsoe brace. Sensory examination notes light touch sensation decreased over the lateral foot, medial foot, medial calf, lateral calf 1st toe on the left side and increased sensation on bilateral anterior thigh; positive allodynia throughout the left foot. The provider is requesting one set of bilateral foot orthotics and plaster splints 4 units.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 bilateral foot orthotics:** 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 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 appear 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 also 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 rear foot 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 more significant effects 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." According to the progress report dated May 29, 2015, the patient has been using orthotics since at least April 2014. Guidelines do not support the use of long term orthotics for the treatment of plantar fasciitis. There is no documentation that the patient developed plantar fasciitis and for foot pain in rheumatoid arthritis. Therefore, the request for 1 bilateral foot orthotics is not medically necessary.

**1 plaster splits 4 units:** 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 Casting. <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, Casting "Recommended for displaced fractures. Immobilization is standard for fracture healing although patient satisfaction is higher with splinting rather than casting." There is no documentation of fracture in this case and the for 1 plaster splits 4 units need for is not clear. The request is not medically necessary.

