

Case Number:	CM15-0174335		
Date Assigned:	09/16/2015	Date of Injury:	07/30/1998
Decision Date:	10/23/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/04/2015

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:

The injured worker is a 50 year old female, who sustained an industrial injury on 07-30-1998. She has reported injury to the bilateral lower extremities. The diagnoses have included arthralgia, fifth MTPJ (metatarsophalangeal joint), right foot; functional instability of the cuboid, lateral right MTJ (midtarsal joint); ankle inversion sprain, right ankle; calcaneo-fibular ankle sprain, right ankle metatarsalgia, fifth metatarsal base-tuberosity; exostosis, at the medial aspect of the left fifth digit DIPJ (distal interphalangeal joint); keratoderma at the medial aspect of the left fifth digit DIP joint; and peroneus longus tendonitis, right lower extremity. Treatment to date has included medications, diagnostics, ice, bracing, night splints, foot orthoses, injection, and home exercise-stretching program. Medications have included Norco, Naproxen, Flector Patch, Cymbalta, Topamax, Nuvigil, Ambien, and transdermal compounded creams. A progress report from the treating provider, dated 08-17-2015, documents a follow-up visit with the injured worker. Currently, the injured worker complains of bilateral lower extremity pain; the pain at the outside of the right foot has increased due to the bone "popping out" since her last visit; left ankle pain remains increased due to previous fall since the last visit; the pain at the right heel is decreased from the last injection and orthotics; the pain at the bilateral arch remains unchanged; the neuritic pain at the left tarsal tunnel remains unchanged and described as "sore"; the neuritic pain at the right tarsal tunnel is slight decreased; the pain at the ball of the right foot is increased; her overall pain currently ranges from 9 out of 10 in intensity at worst, to 7 out of 10 in intensity at best; and both of her ankles "feels unstable" and her "old ankle brace for the right ankle is worn out". Objective findings have included nucleated porokeratotic lesion, with deep central

core, noted at the left foot, medial aspect of the left fifth digit DIP joint, with severe tenderness to palpation of the same; minimal neuritic tenderness to palpation of the left lower extremity and ankle; palpation and percussion over this tarsal tunnel elicits Tinel's sign and Valleix's sign, with + 1 edema present; mild neuritic tenderness to palpation of the right lower extremity and ankle; palpation and percussion over this tarsal tunnel elicits Tinel's sign and Valleix's sign, with + 1 edema present; severe tenderness to palpation at the plantar ball of the left foot, at the third metatarsal interspace; and upon palpation and percussion, positive Tinel's sign and Valleix's sign are present. The treatment plan has included the request for corticosteroid injection at the third MIS (metatarsal interspace) left foot. The original utilization review, dated 08-31-2015, non-certified a request for corticosteroid injection at the third MIS left foot.

IMR ISSUES, DECISIONS AND RATIONALES

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

Corticosteroid injection at the third MIS left foot: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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 post injection response. (Ward, 2008) Evidence is limited. (Colorado, 2001) As there is no evidence supporting the requested injection, medical necessity cannot be affirmed. The injured worker presents with pain in the intermetatarsal space which might be consistent with Morton's Neuroma, for which corticosteroids are not recommended. The request is not medically necessary.