

<b>Case Number:</b>	CM15-0176918		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	12/09/2001
<b>Decision Date:</b>	10/21/2015	<b>UR Denial Date:</b>	08/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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, New York  
 Certification(s)/Specialty: Podiatrist

### 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 59 year old male, who sustained an industrial injury on 12-9-01. The injured worker was diagnosed as having plantar fasciitis; fasciosis left foot; posterior tibial tenosynovitis left foot; sural nerve entrapment with neuritis; posttraumatic arthrofibrosis; synovitis with impingement lesion left ankle. Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 6-17-15 indicated the injured worker complains of "a constant pain level of 2-3 out of 10 at rest to her left foot and ankle. Prolonged repetitive weight bearing activities increased her pain level to 6-7 out of 10 with associated tingling." The provider documents a physical examination noting "moderate tenderness was noted to the plantar medial aspect of the left heel in the area of the plantar fascia which does extend into the medial arch. There is also mild-to-moderate tenderness noted to the posterior tibial tendon from the medial malleolus to the insertion oat the navicular. Mild-to-moderate tenderness is noted to the lateral gutter of the left ankle as well as anterior talofibular ligament region." He continues his examination with "She is also found to have moderate tenderness to the lateral aspect of her left foot at the sural nerve just inferior and posterior to the lateral malleolus which extends with ha Tinel's that radiates distally. 1+ edema is noted in this region with mild induration as well. Range of motion for the forefoot, midfoot, hind foot and ankle is equal and bilaterally symmetrical. There is no evidence of ankle or subtalar joint instability." He notes her walk with a perceptible limp and the stride is shortened on the left side. He notes her excessive pronation instability throughout the entire stance phase of gait. He documents a neurological examination as "There is no palpable or visible fasciculations. Muscular strength in the lower extremities is equal and

bilaterally symmetrical. Vibratory sense proprioception and pinprick are well-preserved in the lower extremities. Deep tendon reflexes to the patella and Achilles are +2 out of 4 and the plantar response is flexor." The vascular portion of his examination documents "The dorsalis pedis and posterior tibial pulses are 2 out of 4 and bilaterally symmetrical. There is no elevation pallor of dependent rubor. The subpapillary venous plexus filling time to all digits is within normal limits. There is no evidence of significant venous disease and the feet are equal in color and temperature." Prior treatment has included a request for a pair of motion-control orthotics for plantar fasciitis and posterior tibial tenosynovitis and night splint for the same. Orthotics, night splint and same injections have been requested since PR-2 notes dated 2-25-15. A Request for Authorization is dated 9-3-15. A Utilization Review letter is dated 8-12-15 and non-certification was for Cortisone Injection, Left Ankle, for lateral impingement lesion, Qty 3 and Cortisone Injection/Nerve Block, Left Ankle, to entrapped sural nerve, Qty 3. Utilization Review denied the requested treatment for not meeting the CA MTUS and ACOEM Guidelines - Ankle and Foot Complaints. Utilization Review Letter stated "the record did not reveal a recent course of conservative treatment such as physical therapy, or exercise or activity modification to address current flare-up of this chronic injury. As per guidelines, injection treatments can be considered when there is a suboptimal response to conservative treatment to address flare of a chronic injury as in this clinical setting." The provider is requesting authorization of Cortisone Injection, Left Ankle, for lateral impingement lesion, Qty 3 and Cortisone Injection/Nerve Block, Left Ankle, to entrapped sural nerve, Qty 3.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cortisone Injection, Left Ankle, for lateral impingement lesion, Qty 3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Ankle and Foot Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, Physical Methods.

**Decision rationale:** Diagnosis is based upon physical examination, which is expected to be the first step in evaluating the possibility of a lateral impingement lesion. The record has no mention of diagnostic study applied to evaluate lateral ankle impingement. MTUS, Table 14-6, recommends arthroscopy of the affected ankle for synovial impingement before conservative care, including injections, is tried. Table 14-5, Table 14-6 do not recommended repeated or frequent injections. Satisfactory results are known to be achieved in the treatment of joint impingement with physical rehabilitation. As per MTUS, pages: 374-6, failure of exercise programs and physical therapy to increase the range of motion of the structures around the ankle has not been demonstrated, in the supplied record. The record provides no evidence of diagnostic study or alternatives to injection therapy, as recommended by the MTUS guidelines. As per MTUS guidelines, at present the proposed injection is not medically necessary.

**Cortisone Injection/Nerve Block, Left Ankle, to entrapped sural nerve, Qty 3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Ankle and Foot Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, Physical Methods.

**Decision rationale:** Peripheral nerve entrapment is addressed in MTUS as is non-specific foot and ankle pain. Diagnosis based upon physical examination, is expected to be the first step in evaluating the possibility of a nerve entrapment syndrome. Corroborative tests for sural nerve dysfunction may include: EMG, Nerve biopsy, nerve conduction studies, ultrasound and MRI. The record provides no evidence of diagnostic study. Nerve entrapment syndromes are known to be responsive to conservative measures to relieve nerve compression. There are a variety of strategies recommended, including: bracing, therapeutic foot wear, orthotics, physical therapy and work status regimens. The record provides no evidence of diagnostic study or alternative therapy as recommended by the MTUS guidelines. As per MTUS guidelines the proposed injection is not medically necessary.