

Case Number:	CM15-0178661		
Date Assigned:	09/18/2015	Date of Injury:	11/08/2013
Decision Date:	10/29/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/10/2015

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 59 year old male, who sustained an industrial injury on 11-08-2013. He has reported injury to the right lower extremity. The injured worker has been treated for knee pain; knee effusion; osteoarthritis knee; degeneration arthritis and osteochondral lesion, right ankle; and gross right ankle instability. Treatment to date has included medications, diagnostics, bracing, physical therapy, home exercise program, and surgical intervention. Medications have included Percocet, Norco, and Advil. Surgical intervention has included right total knee replacement, on 02-11-2015; and right knee manipulation under anesthesia, on 05-01-2015. A progress report from the treating provider, dated 08-03-2015, documented an evaluation with the injured worker. The injured worker reported right ankle pain; the pain is rated at 8 out of 10 in severity; the pain is intermittent in the right foot and ankle and described as sharp, throbbing, and aching; precipitating causes of pain include prolonged standing, walking, and climbing; there are no improvements; he continues to have feelings of instability, noting limping because of the pain; and he can only ambulate an hour or so before having symptoms. Objective findings included marked weakness of the peroneal tendons, especially the peroneus longus at 4 out of 5; there is pain with palpation of the peroneal tendons posterior to the fibula and along the distal course of the peroneus longus at the master knot and inferior surface of the proximal first metatarsal; decreased ankle range of motion; there is evidence of significant anterior excursion; moderate crepitus; pain with ranges of motion; sharp pain with palpation of the distal third interspace with noted Mulder's click; gait and station are antalgic, secondary to use of the knee brace; and the MRI revealed multiple osteochondral lesions about the ankle along with likely ligament damage. The treatment plan has included the request for cortisone injections x 2 to right ankle. The original utilization review, dated 08-26-2015, non-certified a request for cortisone injections x 2 to right ankle.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cortisone injections x 2 to right ankle: Upheld

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

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 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) As there is no evidence supporting the requested injection, medical necessity cannot be affirmed. The documentation submitted for review does not contain a compelling rationale for ankle injection. The request is not medically necessary.