

<b>Case Number:</b>	CM13-0023739		
<b>Date Assigned:</b>	11/15/2013	<b>Date of Injury:</b>	11/30/2010
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	09/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 32 year old male with a work injury dated 11/30/10. The diagnoses include pain in the ankle joint and pain in the leg. Under consideration is a request for series of nerve block to the right ankle. There is a utilization review denial appeal dated 9/17/13. The document states that on the date of the patient's injury he was helping a coworker stack some paper. He became fatigued by the end of the day, and he stepped into a gap that apparently was between the loading gate and the dock hyperflexing his knee and twisting his right ankle. He was seen for medical treatment the next day and was worked up with x-rays and provided with a knee supplies and crutches. He could not bear weight. He had physical therapy and was then worked up with MRI examination of the right ankle. He was then sent to a specialist and was provided with 1 injection into the ankle and was then told that he needed surgery. The patient continues to have severe right ankle pain. He complains of tingling sensation at right ankle with walking. He is consulting a podiatrist for his right ankle pain. He had a single tarsal tunnel injection on 8/5/13 which he says may have helped reduce the pain. He also notices decrease in numbness in the ankle. Patient reports that he continues to work light duty (mostly office work) and is able to tolerate this generally well. Patient reports that the podiatrist did request for 3 serial injections at right ankle. Prior physical exam revealed the patient is a well developed, well nourished male in no acute distress. On ankle examination, dorsiflexion is 5 degrees on right and 10 degrees on left. Planter flexion is 35 degrees on right and 45 degrees on left. Inversion is 20 degrees bilaterally and eversion is 10 degrees bilaterally. There is minimal edema of the lateral ankle. Sensation is grossly intact without apparent dermatomal deficiencies. Patellar, Achilles and Plantar reflexes are 2/4 bilaterally. There is positive Tinel along the dorsal cutaneous nerve as well as tarsal tunnel. The patient continues to have severe light ankle pain. The discussion states that the

documenting physician states that he did review the podiatry consultation report dated 02/26/13 regarding the right ankle. In this report, the physical exam findings do show a positive Tinel along the dorsal cutaneous nerve as well as tarsal tunnel. The patient also reports to have tingling sensation after ambulation which is consistent with his objective findings. In the report, the podiatrist also states that although MRI shows possible partial tear the ankle is stable on examination. Thus, he does recommend a series of 3 nerve blocks to the tarsal tunnel area. The document notes that he would like the intraarticular steroid injections to be combined with physical therapy. The document notes that the patient has tried oral NSAIDs but discontinued them secondary to gastritis. He is currently using topical creams Diclofenac and capsaicin with some benefit. The document states that per the progress report dated 9/6/13, the patient has had a single tarsal tunnel injection by the podiatrist on 8/5/13 which he says has helped reduce the pain. He also notices decrease in numbness in the ankle. Given the positive benefits from the last tarsal tunnel injection and the ongoing right ankle pain, the documenting physician feel that a series of three nerve blocks at right ankle should be authorized. Further info regarding which nerves would be blocked may be clarified by calling the podiatrist's office as this is outside the documenting physician's area of expertise. The document cites the CRPS, sympathetic and epidural blocks.

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

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

#### **SERIES OF NERVE BLOCK TO RIGHT ANKLE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 370. Decision based on Non-MTUS Citation (ODG) Ankle and foot-Injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 371, Chronic Pain Treatment Guidelines CRPS, diagnostic criteria Page(s): 35-37. Decision based on Non-MTUS Citation (ODG) Ankle and foot- Injections.

**Decision rationale:** Series of nerve blocks to the right ankle is not medically necessary per the MTUS and ODG guidelines. Per the MTUS ACOEM injections of corticosteroids or local anesthetics or both should be reserved for patients who do not improve with more conservative therapies. Steroids can weaken tissues and predispose to reinjury. Local anesthetics can mask symptoms and inhibit long-term solutions to the patient's problem. Both corticosteroids and local anesthetics have risks associated with intramuscular or intraarticular administration, including infection and unintended damage to neurovascular structures. Furthermore the ACOEM MTUS states in regards to the ankle and foot, invasive techniques (e.g., needle acupuncture and injection procedures) have no proven value, with the exception of corticosteroid injection into the affected web space in patients with Morton's neuroma or into the affected area in patients with plantar fasciitis or heel spur if four to six weeks of conservative therapy is ineffective. The ODG states that injections for the foot/ankle are under study with limited quality evidence. The documentation submitted does not reveal exam findings suggestive of CRPS. The request does not state which nerve will be injected. The request does not indicate a quantity of injections. The request for series of nerve blocks to the right ankle is not medically necessary.

