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Notice of Independent Review Decision

Date: July 24, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Alcohol injections x6 (2 per visit) 64640 CPT

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Injury 1

- Office visits (03/04/13 - 05/30/13)
- Utilization reviews (06/10/13, 06/28/13)

Square Podiatry

- Office visits (02/18/13 - 06/18/13)
- Procedures (03/15/13 - 04/26/13)
- Utilization reviews (06/10/13, 06/28/13)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was injured on xx/xx/xx, when she was getting water and another let the stabilizer bar down causing it to go under her foot. She suffered injuries to all five toes in the left foot.

No records are available from August 2009 through January 2013.

On February 18, 2013, DPM, evaluated the patient for left foot problems. He noted the patient had a reflex sympathetic dystrophy (RSD) and the RSD was really bothering her. She presented for a pain injection in the area of her ankle joint. Examination showed hypersensitivity upon palpation in the distal aspect of the left great toe. There was apparently a stump neuroma located in that region. There was neuropathic pain in the interspace of the second and third toe of the left foot consistent with stump neuromas. The pain was progressively getting worse. Dr. diagnosed RSD, neuroma deformity in the second and third interspace of the left foot and neuroma deformity in the distal aspect of the amputated hallux. He performed a pain injection in the area of the ankle joint, utilizing lidocaine, Marcaine, Decadron and Depo-Medrol. A sterile dressing was applied. Dr. recommended performing three sets of neurolysis injections, a total of two injections per set. One injection would be performed in the second interspace and the other would be performed in the area of the third interspace.

On March 4, 2013, the patient presented for neuropathic pain as well as crush injury to the foot leading to amputations. She stated that she had recently received a new brace for her foot and ankle. She continued to have hypersensitive in the distal aspect of her digits and some neuropathic pain in the second and third interspaces of her foot. Dr. diagnosed neuritis, complex regional pain syndrome (CRPS) and crush injury. He prescribed Ted hose for continuous inflammation and swelling and recommended proceeding with the neurolysis injections.

On March 14, 2013, Dr. noted that the patient was preauthorized and approved for a total of two neurolysis injections. She continued to have signs of causalgia. Neuropathic pain was noted in the very distal aspect of her toe on the left side which had noticeable hard spots starting to develop. The patient had some neuropathic pain and causalgia pain overall with associated metatarsalgia. The patient had a partial amputation of the great toe as well as total amputation of the second digit.

On March 15, 2013, Dr. performed neurolysis injections to the area of the second and third interspace of the left foot.

On March 18, 2013, the patient reported she felt almost 40% better from the first set of injections. She continued to have hypersensitivity upon palpation in the second and third interspace of her most distal aspect of the great toe, all left side

caused from the crush injury. Dr. diagnosed stump neuroma/neuritis secondary from crush injury to the left foot and amputation and recommended another three sets of neurolysis injections.

On April 1, 2013, the patient stated that she hardly had any pain for two weeks but the pain was now starting to come back on her. Examination showed some scar tissue formation and neuropathic pain. There were slight signs of CRPS. There were also isolated signs of stump neuromas as well as nerve entrapments due to the crush injury to the foot. These localized nerve entrapments had been injected thoroughly. The patient had improved but the pain was slightly starting to come back on her. Dr. recommended going through a series of injections.

On April 8, 2013, Dr. gave preoperative and postoperative instructions and dispensed postoperative medications.

On April 12, 2013, Dr. performed neurolysis injection to the area of the second and third interspace of the left foot and distal aspect of digits as well as other spots throughout the area.

On April 19, 2013, and April 26, 2013, Dr. performed neurolysis injection into the second and third interspace of the left foot.

On May 6, 2013, Dr. noted that the neuropathic pain had reduced substantially due to the neurolysis injections. The patient had improved dramatically. She continued to have some internal derangement and some minor crepitation and pain upon range of motion (ROM) of her ankle joint. Dr. performed injection into the ankle joint. The patient said it felt pretty good.

On May 30, 2013, the patient reported that she had received an injection in her ankle joint last week and the pain was starting to wear off. It gave her some relief but the pain was starting to come back on her. She had some relapse of her neuropathic pain in her foot. She had received a total of three injections in each interspace of her left foot which gave her some relief; however, she was starting to have relapse of symptoms and the pain was starting to come back on her. Examination showed painful neuromas, hypersensitivity on the distal aspect of the great toe as well as the second and third interspace of the left foot, crepitation and pain upon ROM of ankle joint, consistent with internal derangement. Dr. noted that the patient had received neurolysis injections in the past with about 50% improvement and recommended another set of neurolysis injections. The plan was an injection into the second interspace and an injection into the third interspace done the same day times three week apart. It would be a total of six injections.

Per utilization review dated June 10, 2013, M.D., noted following treatment history: The patient was diagnosed with RSD of the lower extremities and plantar nerve lesion of the left foot. Treatment included a chronic pain management program (CPMP), work conditioning, physical therapy (PT), a boot, crutches and

x-rays. Current medication included hydrocodone. A magnetic resonance imaging (MRI) on November 25, 2009, documented amputation of the distal phalanx of the second toe and distal aspects of the distal phalanx of the great toe, soft tissue swelling with edema. The soft tissue swelling was greatest at the level of great toe. Small abscesses could not be ruled out. The patient had a prior electrodiagnostic testing. Dr. denied the request for neurolysis injection into the third and second left foot interspaces x6 (two per visit for three visits) based on the following rationale: *“There are no random, controlled studies to support corticosteroid injections as improving symptoms or as recommended treatment for Morton’s neuroma. There is no objective documentation of decreased pain medication use, decreased pain scores, or increased function with prior injections. The request for neurolysis injections in the second and third interspaces of the left foot (two per visit for three visits) is not certified.”*

On June 17, 2013, the patient reported having a lot of pain in her ankle joint. She stated that the alcohol injections performed in the past had eased a lot of her pain and the additional injections were pending. Examination showed severe metatarsalgia secondary to the crush injury to the foot leading to the amputation. The patient had ongoing signs of causalgia with some neuromatous type pain especially in the distal aspect of her great toe as well as the second and the third interspaces. The patient complained about her brace. She did have crepitation and pain upon ROM of her ankle joint with a lot of swelling. Dr. performed an injection with combination of Marcaine, lidocaine, Decadron and Depo-Medrol and heated up the patient’s old brace and expanded it to the point where it accommodated a lot of swelling associated with the ankle joint. Dr. recommended using extra-depth shoes and considering a possibility of another surgery in the ankle joint in the near future.

On June 18, 2013, the patient presented with continued neuropathic pain associated with neuroma deformity of the second and third interspace as well as neuropathic pain located distally in the great toe region. There was causalgia pain throughout the area. Dr. prescribed an orthotic device in combination with a customized brace to allow full weightbearing and better quality of life. He noted that the patient could not do the same type of work she had been doing in the past. He removed the patient off of work permanently.

On June 28, 2013, M.D., denied the appeal for neurolysis injections into the second and third interspace of the left foot x6 (two per visit for three visits) based on the following rationale: *“I discussed this case with Dr. who reports the claimant did well after the previous injections. Dr. indicated the claimant was able to improve her gait and change from an AFO brace to an ankle brace. This is a non-certification for a reconsideration of neurolysis injections to the second and third interspace of the left foot, six visits, two a visit for three visits. The previous non-certification was due to lack of significant functional gain following the previous injection nor any decreased use of pain medication or decrease in pain scores. The previous non-certification is supported. Additional records were not provided for review. The guidelines for Morton’s neuroma indicate there are*

no specific studies to support corticosteroid injections for the treatment of this condition. Alcohol injections have a high success rate. The claimant has already undergone previous injections to this region, in spite of the provider's indication that significant functional improvement occurred, there is no documentation of significant increased function or decreased use of medication. The claimant only documented short-term relief following the injection. The request for reconsideration of neurolysis injections to the second and third interspace of the left foot, six visits, two a visit for three visits is not certified."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

There is ample evidence that injections of alcohol can be used for treatment of Morton's Neuroma. Also, the patient had documented relief in the chart of improvement, and this was also reported verbally to the reviewing physician in his notes. Thus, this is a scientifically acceptable treatment which has already demonstrated efficacy for this patient.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

<p>Injections</p>	<p>Under study. Limited quality evidence. See specific indications below.</p> <p><i>Heel pain:</i> 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)</p> <p><i>Achilles tendonitis:</i> 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)</p> <p><i>Morton's Neuroma:</i> 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)</p> <p><i>Achilles tendon:</i> Achilles tendon corticosteroid injections have been implicated in achilles tendon ruptures. (Coombes, 2010)</p> <p><i>Intra-articular corticosteroids:</i> 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 postinjection response. (Ward, 2008) While evidence is limited, therapeutic injections are generally used procedures in the treatment of patients with ankle or foot pain or pathology. Ideally, a therapeutic injection will: reduce inflammation; relieve secondary muscle spasm; relieve pain; and support therapy directed at functional recovery. If overused, injections may be of significantly less value. (Colorado, 2001)</p> <p>See also Hyaluronic acid injections; Autologous blood-derived injections; &</p>
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☒ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Hughes RJ, Ali K, Jones H, Kendall S, Connell DA. Treatment of Morton's neuroma with alcohol injection under sonographic guidance: follow-up of 101 cases. *AJR Am J Roentgenol.* 2007 Jun;188(6):1535-9.

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OBJECTIVE: Morton's neuroma is a common cause of forefoot pain. For this study, we assessed the efficacy of a series of sonographically guided alcohol injections into the lesion. **SUBJECTS AND METHODS:** One hundred one consecutive patients with Morton's neuroma were included in this prospective series. An average of 4.1 treatments per person were administered, and follow-up images were obtained at a mean of 21.1 months after the last treatment (range, 13-34 months). **RESULTS:** Technical success was 100%. Partial or total symptom improvement was reported by 94% of the patients, with 84% becoming totally pain-free. **CONCLUSION:** We conclude that 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.