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Notice of Independent Review Decision

DATE: October 27, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Ankle Intra-Articular Steroid Injection (3rd Injection) x 1 20610, J1040, 99213

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

The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her left ankle on xx/xx/xx.

07/18/12: MRI Left Ankle report. IMPRESSION: Corresponding with the marker indicating the site of pain, low grade tibialis anterior and extensor hallucis longus tendon strains. Findings consistent with posterior tibialis tendinopathy. Evidence for an old anterior talofibular ligament injury.

03/19/13: The claimant was evaluated for left ankle pain. She rated her pain as 4/10. The pain was relieved by injection, pain/RX meds, physical therapy and rest. It was noted that she had 24 visits of PT and one previous IA depomedrol injection and was still experiencing swelling and moderate ant/med ankle joint pain. She was taking Celebrex 200 mg daily for knee and ankle. On exam, left anterior drawer and Hoffman's signs were negative. She had tenderness in the left foot/ankle. She had pain-free range of motion. She had normal strength. She had left ankle and foot pain with restricted eversion. There was no assessment/plan submitted for review.

05/24/13: Operative report. POSTOPERATIVE DIAGNOSIS: Chronic left ankle traumatic synovitis/scar formation refractory to aggressive conservative treatment plus limited grade 3 chondral damage anterior tibia distally and anterior talar dome. PROCEDURE PERFORMED: Left ankle arthroscopic major synovectomy/scar resection/chondroplasty.

06/06/13: The claimant was evaluated who reported her status as improving. Her pain score was 6/10. She was taking prescription pain medication for pain 2 per day with good response. She was full weight bearing. She was not using any assistive devices. She was experiencing swelling. She denied calf tenderness, nausea/vomiting and fever/chills. She was not participating in rehabilitation. She was performing home exercises. On exam, range of motion was acceptable. Motor and sensory exam was grossly intact. Pulses were normal. Her gait was antalgic.

03/11/14: The claimant was evaluated for left knee and ankle pain. She rated her pain as 7/10, aggravated with walking and standing. It was noted that WC denied last refill for Flector patches that were helping both the ankle and knee pain. She had been working out (low impact) at gym with left ankle and knee pain. It was noted that Tramadol was not approved. She had not been working (laid off after injury). On exam, her gait was normal. She had mild left ankle swelling. Anterior drawer was normal. She had tenderness to the left foot/ankle. Her strength was normal. She was to follow up in three months.

04/15/14: MRI Left Ankle report. IMPRESSION: Nonspecific intermediate signal in the peroneus longus tendon adjacent to the calcaneocuboid joint. Findings suggest a possible os peroneum 5 mm x 2 mm. Correlate for site of prior tendon repair. No evidence of tendon tear or tenosynovitis. Scarred appearance of the deltoid ligament. No osteochondral lesion of the talar dome or tibial plafond. Intact lateral ankle ligament.

04/22/14: The claimant was evaluated for left ankle pain. It was noted that her weight was 250 pounds with a BMI of 44. Her ankle exam was unchanged. She was to follow up in two months.

06/16/14: The claimant was evaluated for a second left ankle IAS injection. It was noted that she had gained 4 pounds and weighed 254 pounds. Her exam remained unchanged. She had normal lower extremity strength. She was given a left methylprednisolone injection.

07/31/14: The claimant was evaluated for worsening left ankle pain rated at 6/10 with associated symptoms for limping and swelling. It was noted that Celebrex and Tramadol were approved by W/C and were helping significantly. It was noted that she weighed 255 pounds. It was noted that left ankle DM injection #2 at last visit helped reduce pain 80% x 2 wks, now returning. Her ankle exam remained unchanged. The plan was to request a final, 3rd ankle steroid injection. Her diagnosis was tenosynovitis of foot and ankle, traumatic arthropathy involving ankle and foot.

08/06/14: UR. RATIONALE: Based on ODG criteria, further intraarticular injections of corticosteroid would not be indicated. ODG criteria typically do not recommend the role of continual intraarticular injections to the ankle. While the injection itself is not recommended, it should be noted that this individual has already undergone two recent injections, both of which were with no longstanding benefit. The role of a third injection in this individual in such a short period of time would not be supported as medically necessary.

08/19/14: UR. RATIONALE: Initial request was non-certified noting that ODG criteria typically do not recommend the role of continual intraarticular injections to the ankle. While the injection itself is not recommended, it should be noted that this individual has already undergone two recent injections, both of which were with no longstanding benefit. The role of a third injection in this individual in such a short period of time would not be supported as medically necessary. There is insufficient information to support a change in determination, and the previous non-certification is upheld. Current evidence based guidelines note that intraarticular steroid injections are not recommended. Most evidence on the efficacy of intra-articular corticosteroids is confined to the knee, with few studies considering the joints of the foot and ankle. Peer to peer discussion was not achieved despite calls to office.

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

The previous adverse decisions are upheld. The ODG criteria have not been met. Per ODG, intra-articular corticosteroid injections are 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 postinjection response. Additionally, the claimant did not have significant long-term relief with previous ankle intra-articular injections. As the ODG criteria as mentioned above have not been met, the request for Left Ankle Intra-Articular Steroid Injection (3rd Injection) x 1 20610, J1040, 99213 is not medically necessary.

ODG:

<p>Injections (corticosteroid)</p>	<p>Not recommended for tendonitis or Morton’s Neuroma, and not recommend intra-articular corticosteroids. Under study for heel pain. See specific indications below. <i>Heel pain (plantar fasciitis):</i> 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) <i>Tendon (Achilles tendonitis):</i> 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</p>
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	<p>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)</p> <p><i>Morton's Neuroma:</i> 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)</p> <p><i>Intra-articular corticosteroids:</i> 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 postinjection response. (Ward, 2008) Evidence is limited. (Colorado, 2001)</p> <p>See also Alcohol injections (for Morton's neuroma); Hyaluronic acid injections; Autologous blood-derived injections; Platelet-rich plasma (PRP).</p>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**