

Case Number:	CM14-0170967		
Date Assigned:	10/23/2014	Date of Injury:	09/12/1996
Decision Date:	12/17/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/16/2014

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 Plastic and Reconstructive Surgery and is licensed to practice in Maryland, Virginia and North Carolina. 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 72 year old female with a reported date of injury on 9/12/96 who requested authorization for consultation with an Orthopedic Hand surgeon for severe bilateral carpal tunnel syndrome, as well as repeat fluoroscopic guided right L4-L5 and L5-S1 epidural steroid injection. Documentation from 10/13/14 notes the patient is currently undergoing treatment with medical management including NSAIDs and a history of neuropathic treatment. Lumbar range of motion was restricted by pain. Lumbar and cervical discogenic provocative maneuvers were positive. Tinel's sign and Phalen's test was positive bilaterally. Sensation is reduced in the L4 dermatome and right hand. The patient is diagnosed with right L4 and L5-S1 radiculopathy with right lower extremity weakness, severe bilateral carpal tunnel syndrome and axonal loss with nerve conduction study, central disc extrusion at L4-L5, central disc protrusion at L3-L4 with severe central stenosis, central disc protrusion at L5-S1, L2-L3, bilateral severe L3, L4 and L5 neural foraminal stenosis and lumbar degenerative disc disease. The patient is noted to have failed acupuncture, NSAIDs and bilateral wrist bracing related to severe bilateral carpal tunnel syndrome. She has noted an increase in her symptomatology and is now interested in surgical correction. With respect to the lumbar spine, the patient is noted to have undergone previous steroid injection that provided 80% relief for 15 months. The patient has MRI findings from 9/14/12 noting multiple disc protrusions in the lumbar spine with severe neural foraminal stenosis. The patient has failed physical therapy, NSAIDs, and conservative treatment. Utilization review dated 10/2/14 did not certify the consult and treatment. Reasoning given was that for hand consultation, there was a lack of documentation of previous evaluations and treatment recommendations as well as recent conservative treatment with splinting. With respect to fluoroscopic epidural steroid injection, the patient is noted to have some positive physical examination findings involving the lower extremities; however, no imaging study reports were

provided to be reviewed to confirm the patient has neural compression. "Without documentation of neural compression on imaging diagnostic studies an epidural steroid injection cannot be deemed medically indicated."

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation with an orthopedic hand surgeon for severe bilateral carpal tunnel syndrome: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

Decision rationale: The patient is a 72 year old female with documented severe bilateral carpal tunnel syndrome supported by electrodiagnostic studies who has reported progression of her symptoms. Medical documentation provided by the requesting surgeon was not available to the utilization reviewer, noting this progression and lack of response to conservative management, including NSAIDs and splinting. From ACOEM, page 270, Referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature Fail to respond to conservative management, including worksite modifications Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. Based on the medical records reviewed, the patient is noted to have a progression of her symptoms related to bilateral carpal tunnel syndrome. She has failed conservative management and there is a specific benefit to surgical carpal tunnel release in the appropriate patient. The medical documentation from 10/3/14 was not available to the utilization reviewer and thus this documentation has adequately satisfied the issues noted in the UR. The patient is specifically noted to have undergone conservative management including splinting and has noted the reasoning for requesting surgical intervention at this time. The documentation provided specifically satisfies the ACOEM guidelines and thus referral to hand surgery should be considered medically necessary.

A repeat fluoroscopically-guided right L4-5 and right L5-S1 transforaminal epidural steroid injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: The patient is a 72 year old female with a clear history of lumbar radiculopathy treated with conservative management and confirmed by stated MRI findings. She had previously undergone 1 steroid injection with 80% partial relief. From Chronic Pain

Medical Treatment Guidelines Epidural steroid injections, page(s) 46, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three."Criteria for the use of Epidural steroid injections:Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).3) Injections should be performed using fluoroscopy (live x-ray) for guidance.4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.5) No more than two nerve root levels should be injected using transforaminal blocks.6) No more than one interlaminar level should be injected at one session.7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The patient has evidence of neural compression, based on documentation that was not available previously. The documentation from the requesting surgeon, that was not available to the UR reviewer, satisfies the concerns addressed in the utilization review. Thus, based on these guidelines of well-documented lumbar radiculopathy, treated with conservative management and partial improvement from a previous steroid injection, a second steroid injection is medically necessary.