

Case Number:	CM14-0028482		
Date Assigned:	06/27/2014	Date of Injury:	01/10/2010
Decision Date:	08/14/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/06/2014

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 Internal Medicine and is licensed to practice in Arizona. 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:

On February 3, 2014 this complainant was seen by an orthopedic hand surgeon for a comprehensive evaluation. The patient felt a snap of her hand in 2010, when pulling on a lid from a carton. She had bilateral pain and has had a right elbow surgery. Now she complains of pain in the left palm/wrist radiating to the elbow, shoulder and neck area, tingling and numbness of the left hand and inability to extend the left fingers, especially the long and ring fingers. She has failed physical therapy, chiropractic and acupuncture treatments. A November 2011 was normal. The diagnoses provided after examination and reviewing a 12/27/2013 EMG/NCV (electrodiagnostic study) were: 1) Left median neuropathy carpal tunnel (mild to moderate). 2) Left ulnar neuropathy (mild). The entrapment was at both wrists (cubital tunnel syndrome). 3) Left thumb tendinitis A1 pulley region without triggering. On 8/1/2013, an MRI of the left wrist post arthrogram revealed a tear of the radial attachment of the triangular fibrocartilage while a Bone Scan showed degenerative changes in the small joints of both hands. Observation and possible cortisone injection into the A-1 pulleys of the left ring finger and left thumb were recommended. Then for diagnostic & therapeutic purposes, a Kenalog injection into the left Carpal Tunnel was recommended. An arthritis panel of labs was also requested. This authorization request is for the Carpal Tunnel Injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kenalog injection qty 1 - Carpal Tunnel - Diagnostic/Therapeutic Left: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264-265.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, 272.

Decision rationale: On page 265, the ACOEM states, most invasive techniques, such as needle acupuncture and injection procedures, have insufficient high quality evidence to support their use. The exception is corticosteroid injection about the tendon sheaths or possibly, the carpal tunnel in cases resistant to conservative therapy for eight to twelve weeks. For optimal care, a clinician may always try conservative methods before considering an injection. Carpal tunnel syndrome (CTS) may be treated for a similar period with a splint and medications before injection is considered, except in the case of severe CTS (with thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from CT surgery justify prompt referral for surgery in moderate to severe cases, though evidence suggests that there is rarely a need for emergent referral. Thus, surgery should usually be delayed until a definitive diagnosis of CTS is made by history, physical examination, and possibly electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short lived. Additionally, it is stated on page 272, injections of corticosteroids into CT in mild or moderate cases of CTS after trial of splinting and medication is recommended. Repeated or frequent injection however into CT is not recommended. Clearly this patient has undergone numerous conservative therapies which she has failed. There has been a slow evolution of her diagnosis and it is complicated by multiple issues in the left hand. It is reasonable for the orthopedist to inject this mild to moderate Carpal Tunnel to possibly provide some relief and ultimately to determine if it is a contributor to her pain and whether decompressing the CT would ultimately provide enough relief to justify the surgery. For these reasons, this one Kenalog injection is found to be medically necessary.