

<b>Case Number:</b>	CM14-0061601		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	01/14/2012
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 Orthopaedic Surgery and is licensed to practice in California. 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:

This 42-year-old female restaurant supervisor sustained an industrial injury on 1/14/12, relative to a slip and fall. The 10/3/13 lumbar MRI impression documented a L5/S1 posterior disc protrusion with mild central canal stenosis and lateral recess narrowing. There was possible contact with the central S1 nerve roots. There was L5/S1 mild facet arthropathy causing mild foraminal stenosis. Records indicated that right upper extremity treatment had included physical therapy, injection, thumb spica splinting, anti-inflammatories, and activity modification. Left L5/S1 lumbar epidural steroid injections were performed on 11/13/13 and 2/26/14. Records documented 50-60% relief following the 11/13/13 epidural injection. The 3/20/14 treating physician report indicated the patient 70-80% relief for 3 weeks following the recent epidural injection. She reported recurrence of left lower extremity radicular/sciatic pain that prevented her from ambulating more than 20-30 minutes. She complained of neck pain radiating down the right upper extremity into the first and second dorsal webspace, including the index and long finger. She also reported recurrent pain along the radial aspect of the right wrist associated with picking up objects. Cervical exam documented mild loss of range of motion with pain, right periscapular and paraspinal tenderness, and right upper extremity paresthesias. Lumbar exam findings documented positive straight leg raise testing and signs/symptoms consistent with L5 and S1 nerve root compression. Right shoulder exam documented full range of motion, normal strength, and acromial and subacromial tenderness. Right wrist exam documented mild loss of radial and ulnar deviation and tenderness over the first and second extensor compartments and basal joint. Basal joint grind test was positive. Tinel's and Finkelstein's tests were negative. The diagnosis was improving lumbosacral sprain, quiescent left lower extremity radiculopathy, lumbar internal disc derangement and annular tear at L5/S1, improving right deQuervain's stenosing tenosynovitis, improving right extensor tendinitis of the second dorsal compartment, and right

thumb first CMC sprain and osteoarthritis. The treatment plan requested repeat left L5/S1 translaminar lumbar epidural steroid injection, incision and release of the right first dorsal extensor compartments, post-operative hand therapy for 8 sessions, and cervical spine radiographs six views. Cervical x-rays were requested as the right arm and shoulder pain was not of shoulder etiology but rather cervical etiology. The 4/7/14 utilization review denied the requests for repeat lumbar epidural steroid injection, right upper extremity surgery, post-operative hand therapy, and cervical x-rays. The repeat lumbar epidural steroid injection was denied as the patient had not achieved the level of response to the first injection required by guidelines. The request for right upper extremity surgery and associated hand therapy was denied as there was limited evidence of conservative treatment, and limited clinical findings of deQuervain's tenosynovitis. The request for cervical x-rays was denied based on failure to meet guideline criteria relative to availability of prior studies.

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

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

**Repeat left side L5-S1 translaminar epidural steroid injection under fluroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) supports the use of epidural steroid injections as an option for the treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Repeat injections should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. Guideline criteria have not been met. A left L5/S1 epidural steroid injection was performed on 2/26/14 with 70-80% relief for 3 weeks. There is no indication that medication reduction was achieved or continued for 6 to 8 weeks. Records suggest a similar short duration response to the epidural injection provided on 11/13/13 with 50-60% benefit reported at 2 weeks and returning symptoms noted. Given the failure to meet guideline criteria for repeat injections, this request for repeat left side L5-S1 translaminar epidural steroid injection under fluoroscopy is not medically necessary.

**Incision and release of first dorsal of the right upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, de Quervain's tenosynovitis surgery.

**Decision rationale:** The California MTUS guidelines state that the majority of patients with deQuervain's syndrome will have resolution of symptoms with conservative treatment. Under unusual circumstances of persistent pain at the wrist and limitation of function, surgery may be an option. The Official Disability Guidelines recommend deQuervain's tenosynovitis surgery as an option if there are consistent signs and symptoms and the patient fails 3 months of conservative care with splinting and injection. Surgical treatment of deQuervain's tenosynovitis or hand/wrist tendinitis/tenosynovitis without a trial of conservative treatment, including work evaluation, is generally not indicated. Guideline criteria have not been met. This patient presents with a diagnosis of improving deQuervain's stenosing tenosynovitis. Finkelstein's test is negative. There is no evidence that the patient has failed conservative treatment or that a work evaluation had been completed. Therefore, this request for incision and release of first dorsal of the right upper extremity is not medically necessary.

**Post Op hand therapy for 8 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 21.

**Decision rationale:** As the request for right upper extremity surgery is not medically necessary, the associated request for post op hand therapy for 8 sessions is also not medically necessary.

**Cervical spine radiographs, 6 views:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guides, Neck & Upper Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

**Decision rationale:** The California MTUS guidelines recommend initial studies for acute neck pain when red flags are present for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. The Official Disability Guidelines recommend initial cervical radiographs for patients over 40 with a history of remote trauma. Guideline criteria have been met. There is no evidence in the records that a prior cervical x-ray study has been performed. Given the patient's age, fall history, and chronic pain, this request for cervical spine radiographs (6-views) is medically necessary.