

<b>Case Number:</b>	CM14-0187718		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	10/20/2003
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2014

### 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 Emergency Medicine and is licensed to practice in Wisconsin. 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 37-year-old female who reported an injury on 10/20/2003 due to an unknown mechanism. Diagnoses were bilateral carpal tunnel syndrome, bilateral de Quervain's, and tenosynovitis. Past treatments have been cortisone injections, physical therapy, and medications. Surgical history was not reported. The patient had a physical examination on 10/28/2014, that revealed complaints of both thumbs still triggering at this time. There was pain in the left thumb at the base of the thumb and left lateral epicondyle. The patient also had complaints of right elbow pain. Examination revealed both thumbs had good range of motion. Right wrist had a positive Tinel's and a positive Phalen's. Treatment plan was for an injection into the right thumb and the right epicondyle. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cortisone Injection to the right thumb:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

**Decision rationale:** The decision for cortisone injection to the right thumb is not medically necessary. The California ACOEM states for trigger finger, it is significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after 2 injections by the primary care or occupational medicine provider. The clinical documentation submitted for review did report that the patient had 2 prior cortisone injections into the right thumb. There was no documentation of objective assessment after the injection. The patient has had physical therapy, opioid medication, 2 prior cortisone injections into the thumb with no objective functional improvement documented. The patient continues to complain of her thumbs triggering. The medical guidelines do not support further treatment with injections. There were no other significant factors provided to justify the use outside of current guidelines. Therefore, this request is not medically necessary.

**Cortisone Injection to the right epicondyle:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 30-33.

**Decision rationale:** The request for cortisone injection to the right epicondyle is not medically necessary. CAMTUS/ACOEM recommends injections. This intervention was assessed in acute, subacute (1-3 months), and chronic lateral epicondylalgia patients. Overall, the studies show clear short-term benefits, yet high recurrence rates among injection groups. The level of pain several weeks after injection generally approaches that of the natural history of resolution of the disorder; thus injections (e.g., 1 mL triamcinolone [10 mg/mL] with a 25 or 27 gauge needle) are recommended for short term benefit to reduce the overall magnitude of pain in select cases. In most cases, physicians should carry out conservative measures (i.e., NSAIDs, orthotics, and other non-interventional measures) for 4-6 weeks before considering injections. Generally, there is an inclination to not use more than approximately 3 glucocorticoid injections in any one location for one episode. However, there is no evidence that there is or is not a limit on the number of injections either for an episode or for a lifetime. Subsequent injections should be supported by either objective improvement or utilization of a different technique or location for the injection(s). If symptom relief is obtained, then a proven graduated exercise program for strength and endurance should be considered to maintain and enhance that improvement. It should be noted that glucocorticoid injections have some risks. There is a lack of documentation from previous injections that were not documented with an objective functional assessment, measurements of pain relief and functional improvement. The efficacy from those injections was not reported. Therefore, this request is not medically necessary.