

Case Number:	CM15-0134405		
Date Assigned:	07/22/2015	Date of Injury:	03/13/1995
Decision Date:	09/17/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/13/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic Surgery

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 injured worker is a 57 year old female, who sustained an industrial injury on 3/13/1995. Diagnoses have included right and left shoulder tendinitis and impingement syndrome, lateral epicondylitis of right and left elbow, tendinitis and carpal tunnel syndrome of the right and left wrists and hands, lumbar disc herniation with radiculitis and left hip trochanteric bursitis. Treatment to date has included physical therapy, magnetic resonance imaging (MRI), surgery and medication. According to the progress report dated 6/12/2015, the injured worker complained of increased pain in her cervical spine, upper extremities, lumbar spine and lower extremities. She complained of numbness and tingling radiating down her lower extremities. She reported difficulty sleeping, anxiety and depression. Objective findings revealed positive Tinel's sign for cubital tunnel on the left. There was tenderness in the medial and lateral epicondyle area on the left. Exam of the left shoulder revealed positive impingement on the left and tenderness over the left humerus. Exam of the cervical spine revealed tightness and spasms. Exam of the lumbar spine revealed tightness and spasms. Authorization was requested for a second lumbar spine epidural injection, steroid based injections in the left and right elbow and carpal tunnel release surgery of the right and left hands. Documentation from 3/2/15 noted positive Tinel's and Phalen's overlying the carpal canal with 2 point discrimination greater than 8 mm in the median nerve distribution. Previous conservative management has included bilateral wrist splinting and NSAIDs. Previous electrodiagnostic studies from 2002 noted no evidence of compression neuropathy bilaterally at the carpal tunnel, Guyon's canal and cubital

tunnel. There had not been recent imaging studies to support a diagnosis of lumbar radiculopathy. Conservative management of the lumbar spine had included medical management and lumbar brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Second lumbar spine epidural injection: 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 injection Page(s): 46.

Decision rationale: The patient is a 57 year old female with a stated diagnosis of lumbar disc herniation with radiculitis/radiculopathy status post lumbar epidural steroid based injection with transient relief. A request was made for a second lumbar epidural steroid injection. Examination detail suggests a clinical radiculopathy but this has not been supported by electrodiagnostic studies and/or previous recent imaging studies as recommended from Chronic pain medical treatment guidelines. In addition, a recent comprehensive conservative trial has not been documented other than NSAIDs and a lumbar brace. There has not been a detailed trial of physical methods and exercises. 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 a 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 a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Therefore as the diagnosis had not been confirmed by recent imaging studies or electrodiagnostic studies and the recommended conservative management(exercises, physical methods, NSAIDs and muscle relaxants), has not been sufficiently documented, epidural steroid injection should not be considered medically necessary.

Steroid based injection in right elbow: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 20 and 23.

Decision rationale: The patient is a 57 year old female with documented pain of the bilateral lateral epicondylar regions. A specific, recent trial of comprehensive conservative treatment had not been documented, as recommended by ACOEM. From page 20, initial care is discussed: Patients in clinical settings may be more severe and may require prescription analgesics as first line treatments. If the treatment response is inadequate, such that symptoms and activity limitations continue, prescribed pharmaceuticals, orthotics, or physical methods can be added. Comorbid conditions, side effects, cost, and provider and patient preferences should guide the health care professional's choice of recommendations. Table 3 summarizes options for lateral epicondylalgia. Conservative care often consists of activity modification using epicondylalgia supports (tennis elbow bands), and NSAIDs with standard precautions on potential side effects. From page 23, with respect to steroid injections, Thus, if a non-invasive treatment strategy fails to improve the condition over a period of at least 3-4 weeks, glucocorticoid injections are recommended [Evidence (B), Moderately Recommended]. As recommended conservative management (other than NSAIDs) had not been recently documented, a steroid injection to the right elbow should not be considered medically necessary.

Steroid based injection in left elbow: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 20 and 23.

Decision rationale: The patient is a 57 year old female with documented pain of the bilateral lateral epicondylar regions. A specific, recent trial of comprehensive conservative treatment had not been documented, as recommended by ACOEM. From page 20, initial care is discussed: Patients in clinical settings may be more severe and may require prescription analgesics as first line treatments. If the treatment response is inadequate, such that symptoms and activity limitations continue, prescribed pharmaceuticals, orthotics, or physical methods can be added. Comorbid conditions, side effects, cost, and provider and patient preferences should guide the health care professional's choice of recommendations. Table 3 summarizes options for lateral epicondylalgia. Conservative care often consists of activity modification using epicondylalgia supports (tennis elbow bands), and NSAIDs with standard precautions on potential side effects. From page 23, with respect to steroid injections, Thus, if a non-invasive treatment strategy fails to improve the condition over a period of at least 3-4 weeks, glucocorticoid injections are recommended [Evidence (B), Moderately Recommended]. As recommended conservative management (other than NSAIDs) had not been recently documented, a steroid injection to the left elbow should not be considered medically necessary.

Right Hand Carpal tunnel release surgery: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270 and 272.

Decision rationale: The patient is a 57 year old female with signs and symptoms of possible bilateral carpal tunnel syndrome that has failed some conservative management of splinting and NSAIDs. However, the diagnosis is not supported by electrodiagnostic studies and a consideration for a steroid injection into the carpal canal had not been documented. From page 270, ACOEM, Chapter 11, "Surgical decompression of the median nerve usually relieves CTS symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest post-surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare." Further from page 272, Table 11-7, injection of corticosteroids into the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Therefore, as the diagnosis is not supported by EDS and that a steroid injection had not been considered, right carpal tunnel release should not be considered medically necessary.

Carpal Tunnel Release surgery of the left hand: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270 and 272.

Decision rationale: The patient is a 57 year old female with signs and symptoms of possible bilateral carpal tunnel syndrome that has failed some conservative management of splinting and NSAIDs. However, the diagnosis is not supported by electrodiagnostic studies and a consideration for a steroid injection into the carpal canal had not been documented. From page 270, ACOEM, Chapter 11, "Surgical decompression of the median nerve usually relieves CTS symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest post-surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare." Further from page 272, Table 11-7, injection of corticosteroids into to the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Therefore, as the diagnosis is not supported by EDS and that a steroid injection had not been considered, left carpal tunnel release should not be considered medically necessary.