Case Number:	CM15-0137454		
Date Assigned:	07/27/2015	**Date of Injury:**	06/27/2014
Decision Date:	08/31/2015	**UR Denial Date:**	06/26/2015
Priority:	Standard	**Application Received:**	07/15/2015

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: California, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

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 37 year old female, who sustained an industrial injury on June 27, 2014. She reported recurrent right lateral epicondylitis. The injured worker was diagnosed as having right lateral epicondylitis and right de Quervain's tenosynovitis. Treatment to date has included diagnostic studies, and steroid injection. On February 2, 2015, notes stated that she failed all conservative measures. On February 23, 2015, the injured worker complained of numbness and tingling over the right hand. She complained of dropping objects involuntarily due to weakness of her right hand. She was noted to be feeling better with respect to her right lateral epicondyle after having had a steroid injection. Physical examination revealed positive Tinel, Phalen and Durkan's tests on the right. The treatment plan included a right EMG/nerve conduction study in order to delineate the extent of her carpal tunnel syndrome. On June 26, 2015, Utilization Review modified a request for ultrasound guided steroid injection into the right elbow lateral epicondyle to steroid injection into the right elbow lateral epicondyle without ultrasound guidance and also modified a request for ultrasound guided steroid injection into right carpal tunnel to steroid injection into the right carpal tunnel without ultrasound guidance, citing California MTUS ACOEM and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound guided steroid injection into right elbow lateral epicondyle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 40-46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ultrasound, diagnostic.

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

Decision rationale: Per the MTUS guidelines, There is good evidence that glucocorticoid injections reduce lateral epicondylar pain. However, there is also good evidence that the recurrence rates are high. On the other hand, pain at the time of recurrence is generally not as severe. Thus, despite the problems with recurrence, there is support for utilizing corticosteroid injections in select cases to help decrease overall pain problems during the disorders natural recovery or improvement phase. Quality studies are available on glucocorticoid injections and there is evidence of short-term benefits, but not long-term benefits. This option is invasive, but is low cost and has few side effects. 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]. The documentation submitted for review indicates that the injured worker complains of numbness and tingling over the right hand, with accompanied weakness. Steroid injection to the right elbow is indicated, however, ultrasound guidance is not medically necessary as the region is readily identified through palpation. As such, the request is not medically necessary.

Ultrasound guided steroid injection into right carpal tunnel: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ultrasound, diagnostic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist, & hand, Injection.

Decision rationale: Per the ODG guidelines with regard to steroid injection: Recommended for Trigger finger and for de Quervain's tenosynovitis as indicated below de Quervain's tenosynovitis: Injection alone is the best therapeutic approach. There was an 83% cure rate with injection alone. This rate was much higher than any other therapeutic modality (61% for injection and splint, 14% for splint alone, 0% for rest or non-steroidal anti-inflammatory drugs). (Richie, 2003) (Lane, 2001) For de Quervain's tenosynovitis (a common overuse tendon injury of the hand and wrist), corticosteroid injection without splinting is the preferred initial treatment (level of evidence, B). Compared with non-steroidal anti-inflammatory drugs, splinting, or combination therapy, corticosteroid injections offer the highest cure rate for de Quervain's tenosynovitis. In most patients, symptoms resolve after a single injection. Corticosteroid injections are 83% curative for de Quervain's tenosynovitis, with the highest cure rate vs the use of non-steroidal anti-inflammatory drug therapy (14%), splinting (0%), or combination therapy

(0%). For this condition, corticosteroid injection without splinting is the recommended treatment. (Stephens, 2008) This Cochrane review found one controlled clinical trial of 18 participants that compared one steroid injection with methylprednisolone and bupivacaine to splinting with a thumb spica for de Quervain's tenosynovitis. All patients in the steroid injection group achieved complete relief of pain whereas none of the patients in the thumb spica group had complete relief of pain. (Peters-Veluthamaningal, 2009) The documentation submitted for review indicates that the injured worker complains of numbness and tingling over the right hand, with accompanied weakness. She is diagnosed with de Quervain's tenosynovitis. Steroid injection to the right carpal is indicated, however, ultrasound guidance is not medically necessary as the region is readily identified through palpation. As such, the request is not medically necessary.