

Case Number:	CM15-0169188		
Date Assigned:	09/09/2015	Date of Injury:	04/13/2015
Decision Date:	10/08/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	08/27/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 31-year-old female, who sustained an industrial injury on April 13, 2015. The injured worker reported a cracking sensation to the left wrist with immediate swelling noted. The injured worker was diagnosed as having cervical radiculopathy, right shoulder trapezius strain, and left wrist carpal tunnel syndrome. Treatment and diagnostic studies to date has included electromyogram with nerve conduction velocity, medication regimen, use of a soft sleeve on the wrist, home exercise program, and x-rays of the left wrist. The documentation provided included an electromyogram with nerve conduction velocity performed on June 08, 2015 that was remarkable for right median nerve neuropathy at the right wrist revealing mild carpal tunnel syndrome. In a progress note dated July 15, 2015 the treating physician reports complaints of quick, sharp, shooting pain to the left wrist, decreased grip to the left wrist, and numbness to the wrist. Examination reveals tenderness on palpation to the left wrist and a positive Finklestein's testing. The injured worker's pain level was rated a 6 out of 10. The treating physician noted that the injured worker's home exercise program was noted to improve the injured worker's range of motion and a decrease in pain, but noted that the symptoms flare up with pressure applied to the left wrist and lifting anything with the left wrist. In a progress note dated July 15, 2015, the treating physician requested left wrist carpal tunnel steroid injection, but the documentation did not indicate the specific reason for the requested treatment. On August 19, 2015, the Utilization Review determined the request for retroactive left wrist carpal tunnel steroid injection to be non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Left Wrist Carpal Tunnel Steroid Injection: Overturned

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic), Injections.

Decision rationale: MTUS 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. DeQuervain's tendinitis, if not severe, may be treated with a wrist-and-thumb splint and acetaminophen, then NSAIDs, if tolerated, for four weeks before a corticosteroid, injection is considered. CTS may be treated for a similar period with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from carpal tunnel 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. Trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after two injections by the primary care or occupational medicine provider (see Table 11- 4)." ODG states "Recommend a single injection as an option in conservative treatment. Corticosteroid injections will likely produce significant short-term benefit, but many patients will experience a recurrence of symptoms within several months after injection. In mild cases wait four to six weeks before consider injection, but sooner in severe cases, given the success of surgery, and the success/predictive value of injections. Therapy decisions should branch based on mild versus severe. Carpal tunnel syndrome may be treated initially with a night splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Repeat Injections: As noted above, a single injection is recommended. Additional injections are only recommended on a case-to-case basis. Repeat injections are only recommended if there is evidence that, a patient who has responded to a first injection is unable to undertake a more definitive surgical procedure at that time. The response rate to a single injection ranges from 34% to 90%. Limited long-term effectiveness of steroid treatment has been reported. (Armstrong, 2004) The following documentation is available in regards to repeat injections. A Cochrane review found that local corticosteroid injection provided greater clinical improvement in symptoms at one month compared to placebo. Significant symptom relief past one month has not been demonstrated.

Two local corticosteroid injections did not provide significant added clinical benefits compared to one injection. (Marshall, 2007) There has been only one randomized controlled trial to investigate repeat injections. A single injection (15 mg of Methylprednisolone acetate) was compared to a "series" of injections (baseline and 8 weeks later). All patients had failed splinting as a conservative measure. It was not emphasized but at 24 weeks (168 days) the group that had the placebo second injection had a lower symptom score (implying greater improvement) than the group that received a second steroid injection (13.00 vs. 15.90, respectively). At 40 weeks, the placebo second injection group had a symptom score of 14.10 and the steroid group had a symptom score of 12.60. Surgical decompression was recommended for those patients who remained symptomatic or relapsed after the first injection. (Wong, 2005) A non-controlled study allowing for evaluation of repeat injections found 17 of 46 patients continued enjoying satisfactory relief of carpal tunnel symptoms at 18 months of follow-up, but 13 of these 17 patients required multiple injections. Only 4 patients who had only one injection had adequate symptom control after 18 months. The median interval of pain relief after the first injection was 103 days and the duration of pain relief after repeated injections progressively dropped over the course of the study (range: 96 days to 73 days, with the last duration after 7 injections). (Armstrong, 2004) A non-controlled trial of patients with idiopathic CTS allowing for a maximum of two additional injections (total injections: 3) found that 43% of patients treated with one injection were successfully treated at one month. This dropped to 15% at 3 months (when of the patients received a repeat injection at this time). At six months, 15% of patients received a 2nd injection and 15% received a 3rd injection. Only 19% of patients were successfully treated with a single injection during the 6-month period of treatment. With repeat injections, only 35% of patients were successfully treated at the end of 6 months. (Hagebeuk, 2004) Complications: Axonal injury; Irreversible nerve damage; Steroid effect (hypertension and elevated blood sugar). Advantage of injections: This is an effective short-term treatment that results in minimal sick leave. (Hagebeuk, 2004)" The treating physician has provided documentation of failure of conservative treatment as outlined in the guidelines above. The medical documentation provided indicate this patient had an EMG that was consistent with the diagnosis of carpal tunnel syndrome. Guidelines allow for an injection after failure of conservative therapy. As such, the request for Retro Left Wrist Carpal Tunnel Steroid Injection is medically necessary.