

Case Number:	CM15-0187328		
Date Assigned:	09/29/2015	Date of Injury:	07/28/2014
Decision Date:	11/09/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/23/2015

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 39 year old female, who sustained an industrial injury on 7-28-2014. Medical records indicate the worker is undergoing treatment for right thumb trigger finger, bilateral ulnocarpal wrist pain, bilateral epicondylitis, rule out bilateral carpal tunnel syndrome and bilateral myofascial upper quadrant pain. A recent progress report dated 8-18-2015, reported the injured worker complained of bilateral upper extremities pain-right greater than left. Right arm pain is rated 8 out of 10 and left arm pain is rated 6.5 out of 10. Physical examination revealed range of motion was within normal limits in the elbow, forearm, wrist and digits, bilateral tenderness to the flexor pronator and common extensor origins, first dorsal compartment tenderness and mild tenderness to the ulnar deviation and loading of the right triangular fibrocartilage. Treatment to date has included 3 sessions of acupuncture, hand braces, 6 occupational therapy visits and medication management. She received an injection into the right common extensor origin that increased her pain for 2 days and got relief for 5 days and the benefit has worn off. The physician is requesting bilateral carpal tunnel cortisone injections x 2 and 8 visits of occupational therapy. On 9-11-2015, the Utilization Review noncertified the request for bilateral carpal tunnel cortisone injections x 2 and 8 visits of occupational therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

(B) Carpal tunnel cortisone injections x 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forarm, Hand, and Wrist; Injection.

Decision rationale: Regarding steroid injections, ODG states the following: "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 nonsteroidal 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 nonsteroidal 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 nonsteroidal 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) Trigger finger: There is good evidence strongly supporting the use of local corticosteroid injections in the trigger finger. One or two injections of lidocaine and corticosteroids into or near the thickened area of the flexor tendon sheath of the affected finger are almost always sufficient to cure symptoms and restore function. The treatment of trigger fingers with a local injection of steroids is a simple and safe procedure but the risk of recurrence in the first year is considerable. (Kazuki, 2006) (Murphy, 1995) (Van Ijsselkj, 1998) (Paavola, 2002) Steroid injection therapy should be the first-line treatment of trigger fingers in non-diabetic patients. In diabetics, the success rate of steroid injection is significantly lower. Injection therapy for type 1 diabetics was ineffective in this study. Surgical release of the first annular (A1) pulley is most effective overall in diabetics and non-diabetics alike, with no higher rates of surgical complications in diabetics. (Nimigan, 2006) Steroid injection in the flexor sheath at the level of the A1 pulley is an effective method of treating patients with trigger finger and should be considered as the preferred treatment. This RCT concluded that local injection with triamcinolone acetate is effective and safe for treating trigger finger as compared to placebo injection. The effects of steroid injections last up to 12 months." The employee has neither Trigger Finger nor de Quervain's. Furthermore, the employee received a prior injection, but there is no documentation as to how the new injections fit into an overall treatment plan. Therefore, the request is not medically necessary.

Occupational therapy 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Physical Methods, Job Analysis, Work Activities, Follow-up Visits, Special Studies, Surgical Considerations, Summary, References, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine, and Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

Decision rationale: MTUS Postsurgical Treatment Guidelines for Carpal Tunnel Syndrome cite "limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery." MTUS continues to specify maximum of "3-8 visits over 3-5 weeks". MD Guidelines similarly report the frequency of rehabilitative visits for carpal tunnel (with or without surgical treatment) should be limited to a maximum of 3-5 visits within 6-8 weeks. The employee has already had 6 sessions. The request number of session is in excess of the guidelines. As such, the request for occupational therapy sessions X8 is not medically necessary.