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| <b>Case Number:</b>   | CM15-0089328 |                              |            |
| <b>Date Assigned:</b> | 07/23/2015   | <b>Date of Injury:</b>       | 09/05/2014 |
| <b>Decision Date:</b> | 08/26/2015   | <b>UR Denial Date:</b>       | 04/17/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/08/2015 |

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 41 year old female who sustained an industrial injury on 09/05/2014. Current diagnoses include severe bilateral carpal tunnel syndrome, status post bilateral carpal tunnel releases and bilateral right first CMC degenerative joint disease, and left C7 radiculopathy. Previous treatments included medications, surgical interventions, and injections. Previous diagnostic studies include an EMG on 12/20/2014. Report dated 03/31/2015 noted that the injured worker presented with complaints that included neck pain radiating into the bilateral trapezius, new onset left shoulder pain from the base of the cervical spine to the proximal third of her left arm. She also has complaints of numbness and pain in the wrist and radial three digits of the right greater than left hand, and significant pain at the base of her right thumb. Current medications include Anaprox DS, Lyrica, and Ultram. Pain level was 10 out of 10 on a visual analog scale (VAS). Physical examination was positive for decreased shoulder range of motion with pain, positive impingement testing in the left shoulder, tenderness in the right first CMC joint and carpal tunnels right greater than left. The treatment plan included a request for hand surgery consultation, injected bilateral carpal tunnels and left shoulder, request authorization for a pain management consultation and cervical epidural steroid injection, prescriptions for Norco and Medrol dose pack, and the patient may undergo random urine toxicology screenings to verify medication compliance. The physician documented that the injured worker has developed recurrent pain and numbness in the volar wrists and radial three digits of the right greater than the left. The injured worker is temporarily totally disabled until 05/12/2015. Disputed treatments include hand surgery consultation, 1 cervical epidural steroid injection, Norco, Medrol dose

pack, injection of 1cc of Celestone and 1cc of Marcaine into bilateral carpal tunnels, and injection of 3cc of Celestone and 3cc of Marcaine in the left shoulder subacromial space.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Hand Surgery consultation:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258; 265; 270.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7: Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** According to the ACOEM guidelines, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. ACOEM recommends that occupational health practitioners can refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. In this case, the injured worker has recurrent symptoms of pain and numbness and positive findings on EMG. Based on the guidelines, medical necessity for the request for a hand surgery consultation has been established. The requested consultation is medically necessary.

**Cervical Epidural Steroid 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 ESIs Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ESIs.

**Decision rationale:** According to the California MTUS Treatment Guidelines, epidural steroid injections are recommended as an option for the treatment of radicular pain. Criteria for use of cervical epidural steroid injections (CESI's) include radiculopathy that must be documented by physical exam and corroborated by imaging studies and/or electro-diagnostic testing. The patient should be initially unresponsive to conservative treatments such as exercise programs, physical methods, NSAIDs, and muscle relaxants. Injections should be performed using fluoroscopy for guidance. CESI's are of uncertain benefit and should be preserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. In this case, there is no physical exam evidence of specific radiculopathy. There are insufficient clinical findings of radiculopathy, such as dermatomal sensory loss or motor deficits correlating with a specific lesion identified by objective testing. The MRI shows no nerve root compression. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

**Norco 10/325mg quantity 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. In addition, the MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no documentation of significant pain relief or increased function from the opioids used to date. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Medrol 4mg Dose Pack #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic), Oral corticosteroids.

**Decision rationale:** According to the ODG, corticosteroids are not recommended for chronic pain, except for complex regional pain syndrome (CRPS) or for polymyalgia rheumatica (PMR). There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. Oral corticosteroids have been recommended in limited circumstances for acute radicular pain in the low back. In this case, there is no specific indication for corticosteroid therapy. Medical necessity for the Medrol dose pack has not been established. The requested medication is not medically necessary.

**Injection of 1cc of Celestone and 1cc of Marcaine into bilateral carpal tunnels: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome, Acute and Chronic, Injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Injections for the treatment of carpal tunnel.

**Decision rationale:** According to the ODG, a single corticosteroid injection is an option in conservative treatment for carpal tunnel syndrome (CTS). 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, it is suggested to wait four to six weeks before considering 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. CTS 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). In this case, there is no evidence of carpal tunnel syndrome in either hand. In addition, this patient to be evaluated by hand surgery, which has been found to be medically necessary. Medical necessity for the requested injection has not been established. The requested item is not medically necessary.

**Injection of 3cc of Celestone and 3cc of Marcaine in the left shoulder subacromial space:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome, Acute and Chronic, Injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder injections.

**Decision rationale:** According to the ODG, steroid injections are recommended for certain shoulder conditions. Subacromial injections are useful for a range of conditions including adhesive capsulitis, sub-deltoid bursitis, and impingement syndrome. Steroid injections in these cases are based on pain-related functional benefits and the failure of at least 3 months of PT, exercise, and acetaminophen or NSAIDs. In this case, three months of physical therapy have not been completed but there was some benefit from a limited amount of physical therapy (previously had 6 sessions). There is no indication for the requested injection at this time. Medical necessity for the requested item is not established. The requested item is not medically necessary.