Case Number:	CM15-0089796		
Date Assigned:	05/14/2015	**Date of Injury:**	04/25/2014
Decision Date:	06/19/2015	**UR Denial Date:**	04/16/2015
Priority:	Standard	**Application Received:**	05/11/2015

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 Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 35 year old, male who sustained a work related injury on 4/25/15. The diagnoses have included fracture left distal radius and left wrist sprain/strain. Treatment has included medications. In the PR-2 dated 12/23/14, the injured worker complains of pain, numbness and tingling in left hand/wrist. He has some decreased range of motion in left wrist. He has tenderness over distal radial ulnar junction. He has a positive Phalen's and Tinel's on the left. He has atrophy of left thenar muscles. He has a prominent distal ulna with loss of volar tilt radius. The treatment plan for this visit is requests for an MRI of left wrist, EMG/NCV studies of upper extremities and refills of medications. The requested treatment for this Independent Medical Review is noted in a PR-2 dated 4/28/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound guided cortisone injection for the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), wrist injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Injection Wrist injection. http://www.odg- twc.com/index.html.

Decision rationale: According to ODG guidelines, wrist 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) 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 triamcinolonacetonide is effective and safe for treating trigger finger as compared to placebo injection. The effects of steroid injections last up to 12 months. (Peters-Veluthamaningal, 2008). See also Intralesional steroid injections; Platelet-rich plasma (PRP)." There is no recent documentation that the patient failed conservative therapies. There is no documentation that the patient developed trigger finger or median/ulnar nerve dysfunction at the wrist. Therefore, the request for Ultrasound guided cortisone injection for the left wrist is not medically necessary.