

<b>Case Number:</b>	CM14-0127828		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	05/12/2010
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	07/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 50-year-old female with a date of injury of 05/12/2010. The listed diagnoses per [REDACTED] are: 1. Lateral epicondylitis with early arthritic changes. 2. Tendonitis of the shoulder. According to progress report 05/30/2014, the patient presents with continued pain and tenderness over the lateral epicondyle. Examination revealed tenderness over the lateral epicondyle but no medial tenderness or instability. Patient has full range of motion of the elbow and neurovascular exam is intact. The treater recommends a cortisone injection in the lateral epicondylar area of the elbow. Utilization review denied the request on 07/14/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cortisone injection in the lateral epicondylar area of the right elbow given on 05/30/2014:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-40.

**MAXIMUS 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 (ODG) ODG guidelines have the following: 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). Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases. Nevertheless, surgery should not be performed until the diagnosis of CTS is confirmed by history, physical examination and possible electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis, however the benefit from these injections although good is short-lived. (Various references listed under "Injections") (Marshall-Cochrane, 2002) (AHRQ, 2003) (Armstrong, 2004) (Goodyear-Smith, 2004) (Gerritsen, 2002) (Sevim, 2004) (Aygul, 2005) (Gokoglu, 2005) (Agarwal, 2005) (Dammers, 2005) (Ucan, 2006) Steroid injections and wrist splinting may be effective for relief of CTS symptoms but have a long-term effect in only some patients. Symptom duration of less than 3 months and absence of sensory impairment at presentation are predictive of an improved response to conservative treatment. Selected patients (i.e., with no thenar wasting or obvious underlying cause) presenting with mild to moderate carpal tunnel syndrome may receive either a steroid injection or wear a night wrist splint for 3 weeks. This will allow identification of the patients who respond well to conservative therapy and may not need surgery. (Graham, 2004) A recent clinical trial found that, at 3 months of follow-up, 94.0% of the wrists in the steroid injection group showed improvement; at 6 months 85.5% showed improvement, and at 12 months 69.9% showed improvement. Over the short term, local steroid injection was better than surgical decompression for the symptomatic relief of CTS, but at 1 year, local steroid injection was slightly less effective compared to surgical decompression (but about "as effective"). (Ly-Pen, 2005) Compared with steroid injection, open carpal tunnel release resulted in better symptomatic and neurophysiologic outcome but not grip strength in patients with idiopathic carpal tunnel syndrome over a 20-week period. (Hui, 2005) Local corticosteroid injections provide good symptom relief for CTS for one-month vs placebo (number needed to treat, 2). (Stephens, 2008) This systematic review found that the usefulness of.

**Decision rationale:** This patient presents with continued pain and tenderness over the lateral epicondyle. The treater recommends a cortisone injection in the lateral epicondylar area of the elbow. Utilization review denied the request stating, "There is no documentation of previous conservative treatment to the elbow." ACOEM guidelines states "corticosteroid injections have been shown to be effective, at least in the short term; however, the evidence on long-term effects is mixed, some studies show high recurrence rate among injection groups." (p235,6). For clearer criteria for steroid injections we turn to ODG, which states "Corticosteroid injection does not provide any long-term clinically significant improvement in the outcome of epicondylitis, and rehabilitation should be the first line of treatment in acute cases, but injections combined with work modification may have benefit." In this case, there is no evidence that the patient has tried this injection before. Given the patient's persistent symptoms, it's reasonable to try along with other rehab measures. The request is medically necessary and appropriate.