Case Number:	CM14-0181342		
Date Assigned:	11/06/2014	**Date of Injury:**	08/29/2013
Decision Date:	12/16/2014	**UR Denial Date:**	09/29/2014
Priority:	Standard	**Application Received:**	10/31/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 has a reported date of injury of 08/29/2013. The patient has the diagnoses of right carpal tunnel syndrome, right cubital tunnel syndrome and right lateral epicondylitis. Per the most recent progress notes provided for review from the primary treating physician dated 09/20/2014, the patient had complaints of continued numbness and tingling in the right hand and pain in the right lateral elbow. The physical exam noted tenderness over the right lateral elbow, positive middle finger, Phalen's and Tinel's test. Previous nerve conduction studies showed evidence of bilateral carpal tunnel syndrome. Treatment plan recommendations included nerve block, injection with Celestone and Marcaine, oral medications and topical analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO CELESTONE 4 UNITS AND 2CC MARCAINE 0.5 PERCENT UNDER ULTRASOUND GUIDED: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

Decision rationale: The ACOEM chapter on forearm, wrist and hand complaints and injection therapy 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 therapyfor 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 beforea 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 untila 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). The chapter on elbow complaints in the ACOEM and injections for laterl epicondylitis states: Corticosteroid injections: Twelve articles on corticosteroid injections for lateral epicondylalgia were reviewed, including 10 studies9,10,39,40,41,42,43,44,45,46 and two meta-analyses.47,48 One of the studies was of high quality, seven of intermediate quality, and two of low quality. Evidence consistently demonstrates that steroid injections into the vicinity of the lateral epicondyle produce short-term pain relief more effectively than do either physical therapy or a "wait and see" approach. However, in the long term, steroid injections are less effective in providing pain relief than is physical therapy or a "wait and see approach.9,10,47,48 One study compared a "wait and see" approach (one visit with a family doctor during which the patients were encouraged "to await further spontaneous improvement" and possible recommendation for the use of acetaminophen or an oral non-steroidal anti-inflammatory medication) with corticosteroid injections (into "every tender spot...until the patient was free of pain during resisted dorsiflexion") and physical therapy (9 treatments of pulsed ultrasound, deep friction massage and an exercise program) over a 6 week intervention period. There is good evidence that glucocorticoid injections reduce lateral epicondylar pain. However, there is also good evidence that the recurrence rates are high. On the other hand, pain at the time of recurrence is generally not as severe. Thus, despite the problems with recurrence, there is support for utilizing corticosteroid injections in select cases to help decrease overall pain problems during the disorders' natural recovery or improvement phase. Quality studies are available on glucocorticoid injections and there is evidence of short-term benefits, but not long-term benefits. This option is invasive, but is low cost and has few side effects. Thus, if a non-invasive treatment strategy fails to improve the condition over a period of at least 3-4 weeks, glucocorticoid injections are recommended [Evidence (B), Moderately Recommended]. While both chapters advise that the use of injectable therapy for epicondylitis and carpal tunnel syndrome is a viable treatment option in the light of conservative non-invasive treatment failure, there is no mention of the need for ultrasound guided injection for theses injections. There is no documentation on why the patient would require ultrasound guided injection versus traditional injection. Therefore criteria have not been met per the ACOEM and the request is not medically necessary and appropriate.

NEEDLE PLACEMENT RIGHT LATERAL EXTENSOR ORIGIN.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

Decision rationale: The ACOEM chapter on forearm, wrist and hand complaints and injection therapy 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 untila 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). The chapter on elbow complaints in the ACOEM and injections for laterl epicondylitis states: Corticosteroid injections: Twelve articles on corticosteroid injections for lateral epicondylalgia were reviewed, including 10 studies9,10,39,40,41,42,43,44,45,46 and two meta-analyses.47,48 One of the studies was of high quality, seven of intermediate quality, and two of low quality. Evidence consistently demonstrates that steroid injections into the vicinity of the lateral epicondyle produce short-termpain relief more effectively than do either physical therapy or a "wait and see" approach. However, in the long term, steroid injections are less effective in providing pain relief than is physical therapy or a "wait and see approach.9,10,47,48 One study compared a "wait and see" approach (one visit with a family doctor during which the patients were encouraged "to await further spontaneous improvement" and possible recommendation for the use of acetaminophen or an oral non-steroidal anti-inflammatory medication) with corticosteroid injections (into "every tender spot...until the patient was free of pain during resisted dorsiflexion") and physical therapy (9 treatments of pulsed ultrasound, deep friction massage and an exercise program) over a 6 week intervention period. There is good evidence that glucocorticoid injections reduce lateral epicondylar pain. However, there is also good evidence that the recurrence rates are high. On the other hand, pain at the time of recurrence is generally not as severe. Thus, despite the problems with recurrence, there is support for utilizing corticosteroid injections in select cases to help decrease overall pain problems during the disorders' natural recovery or improvement phase. Quality studies are available on glucocorticoid injections and there is evidence of short-term

benefits, but not long-term benefits. This option is invasive, but is low cost and has few side effects. Thus, if a non-invasive treatment strategy fails to improve the condition over a period of at least 3-4 weeks, glucocorticoid injections are recommended [Evidence (B), Moderately Recommended]. While both chapters advise that the use of injectable therapy for epicondylitis and carpal tunnel syndrome is a viable treatment option in the light of conservative non-invasive treatment failure, there is no mention of the need for ultrasound guided injection for theses injections. There is no documentation on why the patient would require ultrasound guided injection versus traditional injection. Therefore criteria have not been met per the ACOEM and the request is not medically necessary and appropriate.