

Case Number:	CM14-0215542		
Date Assigned:	01/05/2015	Date of Injury:	06/24/2014
Decision Date:	02/24/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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: California, Massachusetts

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 46 year old male who was injured on 6/24/14. Mechanism of injury is described on 11/3/14 clinic note as being that he impaled his right index finger under nail while picking cut roses. He was initially diagnosed with sporotrichosis and treated with fluconazole and doxycycline although he soon developed right index finger and thumb pain. Diagnoses include right elbow lateral epicondylitis, De Quervain's tenosynovitis and infected right index finger. Evaluation by orthopedic surgeon on 10/16/14 he reports radial and ulnar deviation painful movement. On exam there is a positive Finkelstein. Diagnoses was De Quervain's, plan is to attempt cortisone injection to dorsal compartment. According to medical record from 11/19/14 the injured worker reported having lateral epicondyle pain. He had a recent cortisone injection to the right wrist and was having improvement of de Quervain's symptoms. On exam he had positive Finklestein's with pain with abduction and tenderness over the lateral epicondyle and pain with resisted dorsiflexion and supination. Plan is to pursue an epicondyle steroid injection. The peer reviewer states guidelines state that cortisone injection is not recommended as a routine intervention for epicondylitis, based on recent research based on ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cortisone Injection for Right Elbow Qty: 1.00: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Treatment for Worker's Compensation, Online Edition Chapter: Elbow

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Elbow Chapter Page(s): 19-23.

Decision rationale: The reviewer did not approve the intervention because of an ODG guideline which states that long term efficacy of steroid injection is limited. According to MTUS guidelines, while physical therapy treatment has less pain relief when compared to corticosteroid injection, physical therapy has been found to have longer duration of pain relief. It is important to note that this is only found to be true in the first few months of lateral epicondylitis, beyond the acute stage steroid injection is found to be more effective in mitigating pain when compared to physical therapy, and long term efficacy is the same. Because of this the MTUS guidelines states there is good evidence that glucocorticoid injections reduce lateral epicondylar pain 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. Thus, if a non-invasive treatment strategy fails to improve the condition over a period of at least 3 to 4 weeks, glucocorticoid injections are recommended [Evidence (B), Moderately Recommended]. The injured worker has tried non-invasive treatment and has failed to improve despite being well over 3-4 weeks. Consequently based on the provided medical records and the MTUS guidelines the corticosteroid injection is medically appropriate.