

Case Number:	CM15-0125433		
Date Assigned:	07/10/2015	Date of Injury:	10/18/2013
Decision Date:	08/05/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/29/2015

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 (IW) is a 57 year old female who sustained an industrial injury on 10/18/2013. She reported repetitive motion injury to the right elbow and right forearm. The injured worker was diagnosed as having acute radial nerve palsy; lateral epicondylitis. Treatment to date has included a debridement right elbow lateral epicondyle, and right radial tunnel release Physical therapy (which was helpful but interrupted), and medications. A MRI done 02/26/2014 was unremarkable, and EMG (electromyogram) nerve conduction testing of the right upper extremity (03/27/2015) was normal. Currently, the injured worker complains of pain in the right elbow. On examination, the right elbow is tender to palpation. A request for authorization is made for the following: 1. Right lateral epicondylar steroid injection; and 2. Right Arcade of Frohse steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right lateral epicondylar steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 22-23. Decision based on Non-MTUS Citation Official

Disability Guidelines: Elbow chapter - Injections (corticosteroid); Pain chapter - Injection with anesthetics and/or steroids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Injections (corticosteroid) <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, elbow injection "Not recommended as a routine intervention for epicondylitis, based on recent research. In the past, a single injection was suggested as a possibility for short-term pain relief in cases of severe pain from epicondylitis, but beneficial effects persist only for a short time, and the long-term outcome could be poor. (Boisauvert, 2004) The significant short-term benefits of corticosteroid injection are paradoxically reversed after six weeks, with high recurrence rates, implying that this treatment should be used with caution in the management of tennis elbow. (Bisset, 2006) While there is some benefit in short-term relief of pain, patients requiring multiple corticosteroid injections to alleviate pain have a guarded prognosis for continued non-operative management. 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. (Assendelft, 1996) (Bowen, 2001) (Reveille, 1997) (AHRQ, 2002) (Newcomer, 2001) (Smidt, 2002) (Stahl, 1997) (Crowther, 2002) (Smidt, 2005) A recent clinical trial of treatments for epicondylitis found that, after 12 months, the success rate for physical therapy (91%) was significantly higher than injection (69%), but only slightly higher than in the wait-and-see group (83%). (Korthals-de Bos, 2004) According to another study, botulinum toxin injection may improve pain over a three-month period in some patients with lateral epicondylitis, but injections may be associated with digit paresis and weakness of finger extension. (Wong, 2005) Steroid injection was associated with an increase in reported pain for the first 24 hours of treatment, but the therapeutic benefits compared with naproxen and placebo were evident 3 to 4 days after the start of treatment. (Lewis, 2005) On the basis of the results of this study, the study authors advocate steroid injection alone as the first line of treatment for patients presenting with tennis elbow demanding a quick return to daily activities. (Tonks, 2007)" ODG guidelines do not recommend elbow injection for any elbow injection including epicondylitis. There is no clear evidence of the efficacy of the 2014 elbow injection. There is no documentation supporting the use of elbow injection in this case. Therefore, the request is not medically necessary.

Right Arcade of Frohse steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 22-23. Decision based on Non-MTUS Citation Official Disability Guidelines: Elbow chapter - Injections (corticosteroid); Pain chapter - Injection with anesthetics and/or steroids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Injections (corticosteroid) <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, elbow injection "Not recommended as a routine intervention for epicondylitis, based on recent research. In the past, a single injection was suggested as a possibility for short-term pain relief in cases of severe pain from epicondylitis, but beneficial effects persist only for a short time, and the long-term outcome could be poor. (Boisauvert, 2004) The significant short-term benefits of corticosteroid injection are paradoxically reversed after six weeks, with high recurrence rates, implying that this treatment should be used with caution in the management of tennis elbow. (Bisset, 2006) While there is some benefit in short-term relief of pain, patients requiring multiple corticosteroid injections to alleviate pain have a guarded prognosis for continued non-operative management. 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. (Assendelft, 1996) (Bowen, 2001) (Reveille, 1997) (AHRQ, 2002) (Newcomer, 2001) (Smidt, 2002) (Stahl, 1997) (Crowther, 2002) (Smidt, 2005) A recent clinical trial of treatments for epicondylitis found that, after 12 months, the success rate for physical therapy (91%) was significantly higher than injection (69%), but only slightly higher than in the wait-and-see group (83%). (Korthals-de Bos, 2004) According to another study, botulinum toxin injection may improve pain over a three-month period in some patients with lateral epicondylitis, but injections may be associated with digit paresis and weakness of finger extension. (Wong, 2005) Steroid injection was associated with an increase in reported pain for the first 24 hours of treatment, but the therapeutic benefits compared with naproxen and placebo were evident 3 to 4 days after the start of treatment. (Lewis, 2005) On the basis of the results of this study, the study authors advocate steroid injection alone as the first line of treatment for patients presenting with tennis elbow demanding a quick return to daily activities. (Tonks, 2007)" There is no clear evidence of radial neuropathy and the requested injection is not medically necessary. Therefore, the request for Right Arcade of Frohse steroid injection is not medically necessary.