

<b>Case Number:</b>	CM15-0060771		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	04/01/2014
<b>Decision Date:</b>	05/18/2015	<b>UR Denial Date:</b>	03/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 43-year-old female, who sustained an industrial injury on 04/01/2014. She has reported subsequent low back, bilateral upper extremity, left wrist and left thumb pain and was diagnosed with sprain/strain of band, enthesopathy of elbow region and lumbar sprain/strain. Treatment to date has included oral pain medication, wrist wraps, application of heat and a home exercise program. In a progress note dated 03/04/2015, the injured worker complained of left thumb, left wrist, low back and bilateral arm pain. Objective findings were notable for pain to palpation at deltoid of the left arm, pain to palpation along the lateral epicondyle of the left elbow, pain with flexion and extension of the left wrist and on palpation of the dorsal wrist and pain to palpation of the right paralumbar back. Straight leg raise sign is negative. There is normal gait, intact reflexes and 5/5 motor strength in the legs. The patient can heel and toe walk. A request for authorization of epidural steroid injection, MRI of the left wrist and ultrasound-guided injection of the left thumb was submitted. A 4/2/14 lumbar spine x-ray and lumbar MRI were reported normal. Per documentation dated 3/4/15 the patient had a lumbar epidural steroid injection 1/29/15. Per documentation a 2/4/15, follow up states that her low back feels "60%" of normal.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Epidural Steroid Injection #2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46.

**Decision rationale:** Epidural Steroid Injection #2 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The documentation submitted does not reveal evidence of objective nerve compression or suggestion of radiculopathy on physical exam or imaging studies. Additionally, the request does not specify a level, laterality, or evidence of the proposed injection. Furthermore, there is no documentation of 50% pain relief with associated reduction of medication use for six to eight weeks after the first epidural injection. Therefore, the request for epidural steroid injection is not medically necessary.

## **MRI of the Left Wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

**Decision rationale:** MRI of the Left Wrist is not medically necessary per the MTUS ACOEM guidelines. The documentation indicates a positive Finkelstein's test on the left wrist suggesting DeQuervain's tenosynovitis, which is not diagnosed by imaging studies. There are no other indications documented that would necessitate a wrist MRI therefore this request is not medically necessary.

## **Ultrasound Guided Left Thumb Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist, hand- Injection.

**Decision rationale:** Ultrasound guided left thumb injection is not medically necessary per the MTUS ACOEM Guidelines and the ODG. The ACOEM states that an initial injection into tendon sheath for clearly diagnosed cases of DeQuervain's syndrome. The ODG also states that an injection can be performed for DeQuervain's. Neither of the guidelines discusses the necessity of ultrasound-guided imaging for this simple procedure. The documentation does not indicate

extenuating circumstances as to why the injection cannot be performed without location of specific landmarks without ultrasound. Therefore, this request is not medically necessary.