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Notice of Independent Review Decision

DATE OF REVIEW: 11/1/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a corticosteroid injection to the right wrist.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years in this field.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a corticosteroid injection to the right wrist.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Sports Medicine and.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: Sports Medicine: 11/18/08 through 9/13/10 reports from, 1/10/08 through 2/6/08 reports by DPM, 9/27/10 PT script, 9/7/10 right elbow MRI report, unreadable date work release from WSM, 7/15/10 to 7/21/10 notes from, injury report from 7/15/10, DWC 69 dated 11/18/08 w/o report and 1/10/08 report by MD.

9/8/10 and 9/21/10 preauth request forms, 7/28/10 through 8/26/10 office notes from, 8/12/10 right shoulder arthrogram report, 9/21/10 appeal letter from and 9/28/10 denial letter.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee's initial complaints were associated with repetitive use of the right arm, and, located at the shoulder and elbow. The clinical and imaging findings for those areas were noted. The shoulder and elbow were injected as the claimant's history of intolerance to NSAIDs was noted.

The claimant initially complained of dorsal wrist pain. Exam findings included CMC joint tenderness. Wrist x-rays only revealed an apparent benign cyst in the scaphoid. A diagnosis rendered by the Attending Physician was first CMC capsulitis. An appeal letter from 9/21/10 denoted that the wrist had an indication for multiple injections. Denial letters reflected that the claimant was being considered for injections related to trigger finger and/or tenosynovitis of wrist pathology. The letters also discussed a lack of failure of less invasive techniques (including therapy) as treatment of wrist pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Without a documented trial and failure of reasonable non-operative treatment of the thumb CMC capsulitis (including PT, medications, splinting, etc.), there is no guideline-associated indication for a corticosteroid injection (or series) at this time. Note: Despite the ODG criteria referencing tenosynovitis et al., the references utilized herein all support the utilization of corticosteroid injections when medically reasonably required only.)

***ACOEM - Injections* - INTRAARTICULAR INJECTIONS:**

Intraarticular glucocorticosteroid and hyaluronidate injections are sometimes performed to attempt to deliver medication with minimal systemic effects to the arthritic joint, (Stolzer 62; Heyworth 08; Roux 07; Wollstein 07; Stahl 05; Fuchs 06; Meenhagh 04; Day 04) particularly when acetaminophen and NSAIDs have failed. These injections are generally performed without fluoroscopic or ultrasound guidance in the distal upper extremity.

Intraarticular glucocorticosteroid injections are recommended for the treatment of subacute or chronic hand osteoarthritis. *Indications* –Moderately severe or severe hand osteoarthritis pain with insufficient control with NSAID(s), acetaminophen, and potentially splinting and/or exercise. Its usual purpose is to gain sufficient relief to either resume medical management or to delay operative intervention.

Frequency/Duration – One (1) injection should be scheduled, rather than a series of 3. Various medications have been used, as well as adjuvant anesthetic agents. There are no head-to-head comparisons in quality studies of different medications to ascertain optimum medication(s).

Dose – Various doses have been utilized without evidence to identify an ideal dose for hand or phalangeal joints.

Indications for Discontinuation – A second glucocorticosteroid injection is not recommended if the first has resulted in significant reduction or resolution of symptoms. If there has not been a response to a first injection, there is generally less indication for a second. If the physician believes the medication was not well placed and/or if the underlying condition is so severe that one steroid bolus could not be expected to adequately treat the condition, a second injection may be indicated. If placement is thought to be difficult, ultrasound or fluoroscopic guidance may be particularly indicated for a second injection. In patients who respond with a pharmacologically appropriate several weeks of temporary partial relief of pain, but who then have worsening pain and function and who are not (yet) interested in surgical intervention, a repeat injection is an option. There are not believed to be benefits beyond approximately 3 injections in a year. Patients requesting a 4th injection should have reassessment of non-operative management measures and be counseled for possible surgical intervention.

ODG – Injections:

Recommended for Trigger finger and for de Quervain's tenosynovitis as indicated below.

de Quervain's tenosynovitis: Injection alone is the best therapeutic approach. There was an 83% cure rate with injection alone. This rate was much higher than any other therapeutic modality (61% for injection and splint, 14% for splint alone, 0% for rest or nonsteroidal anti-inflammatory drugs). For de Quervain's tenosynovitis (a common overuse tendon injury of the hand and wrist), corticosteroid injection without splinting is the preferred initial treatment (level of evidence, B). Compared with nonsteroidal anti-inflammatory drugs, splinting, or combination therapy, corticosteroid injections offer the highest cure rate for de Quervain's tenosynovitis. In most patients, symptoms resolve after a single injection. Corticosteroid injections are 83% curative for de Quervain's tenosynovitis, with the highest cure rate vs the use of nonsteroidal anti-inflammatory drug therapy (14%), splinting (0%), or combination therapy (0%). For this condition, corticosteroid injection without splinting is the recommended treatment. This Cochrane review found one controlled clinical trial of 18 participants that compared one steroid injection with methylprednisolone and

bupivacaine to splinting with a thumb spica for de Quervain's tenosynovitis. All patients in the steroid injection group achieved complete relief of pain whereas none of the patients in the thumb spica group had complete relief of pain.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

Maarse W, Watts AC, Bain GI. Medium-term outcome following intra-articular corticosteroid injection in first CMC joint arthritis using fluoroscopy. Hand Surg. 2009;14(2-3):99-104.

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**