

<b>Case Number:</b>	CM14-0010937		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	08/23/2012
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	12/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2014

### 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 Arizona. 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:

Patient is a 49 year old female with a date of injury on 8/23/2012. The patient has been treated for ongoing symptoms in the right arm. Diagnoses include right forearm sprain, right elbow sprain/strain, and right wrist sprain rule out carpal tunnel syndrome. Subjective complaints are of numbness and tingling of the bilateral upper extremities, right forearm and elbow pain, and burning right wrist pain with muscle spasm. Physical exam shows tenderness over neck, decreased cervical range of motion, tenderness over rotator cuff attachment sites, and left shoulder decreased range of motion. There is also tenderness at lateral epicondyle, decreased left elbow range of motion, decreased right hand grip strength with decreased range of motion and positive Tinel's and Finkelstein's. Medications include Fanatrex, Dicopanol, Deprizine, Tabradol, Synapryn, Cyclophene gel, and Ketoprofen Gel. Cervical MRI from 8/2013 showed C3-C5 disc protrusions, and degenerative disc disease. Shoulder MRI from 7/2013 revealed rotator cuff tendinosis and acromioclavicular arthrosis. Urine drug screen is documented from 10/18/2013, 11/21/2013, 12/26/2013, and 1/23/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC TREATMENT, RIGHT ELBOW, FOREARM AND WRIST:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION, Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
MANUAL THERAPY Page(s): 58-59.

**Decision rationale:** CA MTUS guidelines do not support the use of chiropractic manipulation for the forearm, wrist, or hand. Therefore, the medical necessity for chiropractic treatment is not established.

**SHOCKWAVE THERAPY RIGHT ELBOW, FOREARM AND WRIST:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ESWT, Shoulder

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College Of Occupational And Environmental Medicine (ACOEM), 2nd Edition, pg. 30 Official Disability Guidelines (ODG), Elbow, ESWT.

**Decision rationale:** ACOEM guidelines suggest that there are quality studies for acute, subacute and chronic lateral epicondylitis that demonstrate no benefit from extracorporeal shockwave therapy (ESWT). The ODG states that the value, if any, of ESWT for lateral elbow pain, can presently be neither confirmed nor excluded. After other treatments have failed, some providers believe that shock-wave therapy may help some people with tennis elbow. While ESWT may be indicated for lateral epicondylitis, there is no guideline support for this therapy on the forearm and wrist. Therefore, the medical necessity of ESWT is not established.

**EMG RIGHT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 182, 213, 261, 269.

**Decision rationale:** ACOEM guidelines suggest EMG as a means of detecting physiologic insult in the upper back and neck. EMG/NCS can also be used to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection, but is not recommended for diagnosis if history, physical, and previous studies are consistent with nerve root involvement. For shoulder complaints ACOEM does not recommend EMG for evaluation for usual diagnoses. For hand/wrist complaints EMG is recommended as an appropriate electrodiagnostic study that may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. For this patient, subjective and objective signs/symptoms show evidence of nerve root involvement and carpal tunnel

**NCV RIGHT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179, 182, 213, 261, 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Wrist, Nerve Conduction Studies.

**Decision rationale:** ACOEM guidelines suggest NCS as a means of detecting physiologic insult in the upper back and neck. EMG/NCS can also be used to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection, but is not recommended for diagnosis if history, physical, and previous studies are consistent with nerve root involvement. For hand/wrist complaints NCV is recommended as appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. The ODG recommends NCS in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. For this patient, subjective and objective signs/symptoms show evidence of nerve root involvement versus carpal tunnel syndrome. Therefore, the medical necessity of a NCS is established.

**RIGHT WRIST BRACE:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist and Hand Splinting.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome, Splinting.

**Decision rationale:** The ODG recommends splinting of the wrist in neutral position at night and day as needed, as an option in conservative treatment for symptoms of carpal tunnel syndrome. This patient has symptoms consistent with carpal tunnel syndrome. Therefore, the request for a wrist brace is medically necessary.

**RETROSPECTIVE URINE DRUG SCREEN DOS: 11/218/13:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Urine Drug Screening.

**Decision rationale:** CA MTUS supports using drug screening to test for illegal drugs and compliance with medication regimens. ODG recommends use of urine drug screening as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and

uncover diversion of prescribed substances. For "low risk" patients of addiction/aberrant behavior, testing should be done within six months of initiation of therapy and on a yearly basis thereafter. This patient is not documented to have aberrant behavior, and has been stable on his chronic medications. Recent drug screening has also documented compliance. Urine drug screening on a monthly basis is not supported by the guidelines or clinical documentation. Therefore, the medical necessity of a urine drug screen on 11/21/13 is not established.