

<b>Case Number:</b>	CM14-0034187		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	03/19/2005
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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:

The injured worker is a 69-year-old female with a reported date of injury on 03/19/2005. The injury reportedly occurred when the injured worker was lifting a patient while working on the floor. Her diagnoses were noted to include probable left cubital tunnel syndrome, left upper extremity overuse syndrome, secondary to injury of 2006, lumbar degenerative disc disease with left L5-S1 radiculopathy, and prior history of L4-5 disc injury. Her previous treatments were noted to include corticosteroid injections, medication, rest, physical therapy, and creams. The physical examination dated 03/18/2014 reported left elbow range of motion 0 to 140 degrees and positive tenderness over the cubital tunnel on the left, decreased sensation of the ulnar 2 digits on the left hand. The lumbar spine flexion was to 30 degrees, extension to 10 degrees, side to side bending to 20 degrees, and side bending to 10 degrees. The progress note also reported the injured worker had completed 4 visits of physical therapy with some improvement of her left elbow pain but still had ongoing paresthesias. The progress note dated 05/16/2014 noted the injured worker reported her left upper extremity symptoms had improved and the ulnar paresthesias had improved as well. The injured worker complained of ongoing pain in the lower back, with the symptoms occasionally into the left leg. The physical examination showed the cervical range of motion flexion was to 30 degrees, extension to 15 degrees, and side to side was to 20 degrees. The lumbar range of motion was noted to be flexion to 30 degrees, extension to 15 degrees, and side to side to 10 degrees. The request for authorization form dated 03/19/2014 was for a lumbar MRI to assess for lumbar radiculopathy L4-5 and L5-S1. The request for authorization form was not submitted for a lumbar support, pillow splint for left elbow, and physical therapy to the left elbow. The provider's rationale was not submitted within the medical records.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar Support:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**Decision rationale:** The request for Lumbar Support is not medically necessary. The injured worker was injured in 2005. The CA MTUS/ACOEM Guidelines do not recommend lumbar support (corset) for the treatment of low back disorders. The Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The injured worker has been having ongoing lumbar complaints and the Guidelines do not recommend lumbar supports except for the onset of symptoms and the injury occurred 9 years ago and is not an acute onset of symptoms. Therefore, the request for Lumbar Support is not medically necessary.

### **Pillow Splint for Left Elbow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 25-26.

**Decision rationale:** The request for Pillow Splint for Left Elbow is not medically necessary. The injured worker had an electrodiagnostic study performed on 04/12/2014, which concluded there is no electrodiagnostic evidence of left elbow ulnar motor neuropathy of the cubital tunnel region. The CA MTUS/ACOEM Guidelines state there is insufficient evidence; however, elbow padding is recommended. The Guidelines do recommend elbow splints; however, the electrodiagnostic study reported the injured worker had no evidence regarding cubital tunnel syndrome and the progress report dated 05/16/2014 reported the injured worker states her left upper extremity symptoms had improved and the ulnar paresthesias had improved. Due to improving symptoms, a pillow splint is not warranted at this time. Therefore, the request for Pillow Splint for Left Elbow is not medically necessary.

### **MRI of the Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The request for MRI of the Lumbar Spine is not medically necessary. The injured worker had an MRI on 03/27/2014. The CA MTUS/ACOEM Guidelines state unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false positive findings, such as disc bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with the consultant the selection of an imaging test to define a potential cause, such as an MRI for neurological deficit. An MRI is used to identify and define low back pathology in regard to disc protrusion, cauda equina syndrome, spinal stenosis, and post laminectomy syndrome. The physical examination performed 02/18/2014 reported tenderness to palpation to the sacroiliac joints, positive straight leg raise, and diminished deep tendon reflexes as well as decreased sensation to the left lower extremity. There is decreased sensation along the L5-S1 distribution to the left noted. The muscle strength to the bilateral lower extremities was rated 5/5. The injured worker had an MRI performed in 03/2014 which reported multilevel degenerative disc disease and facet disease with mild to moderate central stenosis from L2-L5 and at L5-S1. There is a left foraminal disc extrusion which abuts and may mildly compress the exiting left L5 nerve root. There is a lack of clinical findings to warrant a repeat MRI. Therefore, the request for MRI of the Lumbar Spine is not medically necessary.

**Physical Therapy for the Left Elbow (no duration or frequency listed):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The request for Physical Therapy for the Left Elbow (no duration or frequency listed) is not medically necessary. The injured worker has received previous physical therapy to the left elbow. The Chronic Pain Medical Treatment Guidelines recommend active physical therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The Guidelines recommend for myalgia and myositis 9 to 10 visits over 8 weeks. The documentation noted 4 visits to the left elbow of physical therapy and the progress note from 05/2014 reports the injured worker's left upper extremity symptoms have improved and the ulnar paresthesias had improved as well. There is a lack of documentation regarding current measurable objective functional deficits including range of motion and motor strength to the left elbow as well as quantifiable objective functional improvements from previous physical therapy sessions. The documentation provided reported the injured worker's upper extremity symptoms and ulnar paresthesias had improved and due to the lack of documentation regarding current measurable objective functional deficits and quantifiable objective functional improvements with previous treatments, as well as the total number of sessions completed with previous physical

therapy, it is unknown if physical therapy is appropriate at this time. Additionally, the request failed to provide the frequency or duration of physical therapy for the left elbow requested. Therefore, the request for Physical Therapy for the Left Elbow (no duration or frequency listed) is not medically necessary.