

<b>Case Number:</b>	CM14-0069862		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	05/02/2012
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2014

### 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 Neurology and is licensed to practice in California. 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 55 year-old left hand dominant female with a reported date of injury of 5/2/2012. The patient is reporting pain in the lateral aspect of the right upper forearm. The patient is reporting this pain developed while she was working as a cashier. A physical exam was performed on 3/14/14 and is notable for weakness on extension of the right index finger and decreased grip strength in her right hand. A Jamar grip strength evaluation of the right hand reveals an effort of 45 lbs., and 20 lbs., and 20 lbs. respectively. The effort from the left hand is noted to be consistent at 90 lbs. The exam also annotates decreased sensation in the right radial nerve distribution. The patient is reported to have a positive Tinel's sign upon palpation of the right posterior interosseous nerve at the arcade of Froshe. The patient was initially treated with Tramadol for pain control and is reported have marginal improvement. The treating physician believes the cause of the pain is secondary to entrapment of the posterior interosseous nerve at the arcade of Froshe in the right forearm. The previous request for an injection of the right interosseous nerve (with Kenalog) was denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Interosseous Nerve Injection: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 19. Decision based on Non-MTUS Citation Anna-Christina Bevelacqua, MD, Catherine L. Hayter, MBBS, Joseph H. Feinberg, MD, and Scott A. Rodeo, MD Posterior Interosseous Neuropathy: Electrodiagnostic Evaluation. HSS J. Jul 2012; 8(2): 184-189.

**Decision rationale:** As stated on in the ACOEM Elbow Chapter with regards to the treatment of radial neuropathies, there are not quality studies to rely for the treatment of radial neuropathies. The recommend treatment options are non-invasive and include splinting of the wrist and the use of NSAID's. The use of an injection of the posterior interosseous nerve is not one of the recommended therapies and is not considered to be medically necessary. Additional evidence for not approving the request for the injection of the posterior interosseous nerve can be found in this article from the HSS journal. The publication states that posterior interosseous nerve entrapment can be difficult to distinguish from lateral epicondylitis, radial nerve injury, radial tunnel syndrome, cervical radiculopathy, and brachial plexopathy based on physical exam alone and therefore diagnosis may be difficult to make. It is often necessary to perform an electrodiagnostic (EMG and Nerve Conduction) study to confirm the diagnosis. In this case, the provider only has a clinical suspicion that this may be a posterior interosseous nerve entrapment. Although steroid injections have been used to treat this condition, it would not be performed without confirmation of the diagnosis. Therefore, the request for Interosseous Nerve Injection is not medically necessary.