

Case Number:	CM14-0088428		
Date Assigned:	08/08/2014	Date of Injury:	07/29/2013
Decision Date:	10/10/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/12/2014

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 Orthopedic Surgery and is licensed to practice in Indiana. 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 32-year-old female accounts payable specialist with a date of injury of 7/29/13. The worker's job duties were light including bookkeeping and accounting tasks, keyboarding, frequent to repeated pushing, pulling, finger manipulation, gripping, grasping, lifting up to 10 pounds, and 100% sitting. The worker complains of neck pain, bilateral shoulder pain, bilateral arm pain with numbness and tingling, bilateral hand/wrist pain with swelling, weakness, and numbness/tingling, and upper back pain. Diagnoses include mild right ulnar motor neuropathy at the elbow; bilateral shoulder impingement syndrome, tendinosis of the supraspinatus, mild subacromial/subdeltoid bursitis, carpal tunnel syndrome, and complaints of anxiety, depression and difficulty sleeping. A recent physical examination of the worker performed by the treating physician on 5/12/14 documented pertinent positive findings of a positive Neer's Impingement Test and Hawkins-Kennedy Impingement test bilaterally, a positive right elbow flexion test, mild intrinsic weakness of the right hand, increasing pain towards terminal range of motion of the thoracic spine, sensory loss in the right ulnar nerve distribution, a positive Tinel's and Phalen's sign of the right wrist with decreased sensation in the radial 3 digits of the right hand, and positive electrodiagnostic study dated 3/10/14 documenting evidence of mild right ulnar motor neuropathy at the elbow on nerve conduction studies with a normal EMG of the upper extremities. As a result of these findings, the treating physician requested physical therapy 3x/week for 6 weeks for the cervical and thoracic spine and bilateral shoulders; Occupational therapy 2x/week x 3 weeks for bilateral hands/wrists with a history and clinical evidence consistent with right carpal tunnel syndrome; right elbow extension brace and Hellbow support for cubital tunnel syndrome; and right ulnar nerve decompression at the elbow with medial epicondylectomy for cubital tunnel syndrome. Diagnostic testing has included an MRI of the right wrist dated 3/26/14 revealing a small effusion of the distal radioulnar joint with no

evidence of carpal tunnel syndrome; an MRI of the right and left shoulders dated 3/26/14 revealing mild tendinosis of the supraspinatus tendon without tear and mild subacromial/subdeltoid bursitis; an MRI of the thoracic spine dated 3/26/14 revealing T10-11 level 6 mm root sheath cysts in the neural foramina; MRI of the cervical spine revealing straightening of the cervical lordosis consistent with muscle spasm C3-7 with a 1 mm disc protrusion abutting the thecal sac without impingement on the spinal cord or nerve roots. As of 5/12/14, the injured worker's neck pain, bilateral shoulder pain, bilateral arm pain, bilateral wrist/hand pain and upper back pain were 8/10. The worker complains of pain symptoms at work and when performing housework with difficulty caring for her three children. Medical treatment has included Motrin, Naprosyn, Neurontin, and a steroid injection of the trapezius musculature as well as physical therapy and analgesic medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued Physical Therapy 3 times a week for 6 weeks for Cervical Spine, Thoracic Spine, Bilateral Shoulders: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 97-98.

Decision rationale: Although the CA MTUS Chronic Pain Medical Treatment Guidelines allow for active therapy for conditions including myalgia and myositis, unspecified, and neuralgia, neuritis, and radiculitis, unspecified, the number of treatments recommended as medically necessary are 9 - 10 visits over 8 weeks for myalgia and myositis and 8 - 10 visits over 4 weeks for neuralgia, neuritis, and radiculitis, unspecified. The requested treatment of 3 physical therapy visits for 6 weeks or 18 total visits exceeds the recommended number of physical therapy treatments considered as medically necessary. Therefore, the request is not medically necessary.

Occupational Therapy 2 times a week for 3 weeks for Bilateral Hands and Wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 604.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 15 - 16.

Decision rationale: According to the CA MTUS Postsurgical Treatment Guidelines for Carpal Tunnel Syndrome, there is limited evidence demonstrating the effectiveness of physical therapy or occupational therapy for CTS (carpal tunnel syndrome). Carpal tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits. The evidence may justify 3 - 5 visits over 4 weeks after surgery. As the patient has not undergone surgery for

clinical symptoms and physical findings consistent with carpal tunnel syndrome, the requested occupational therapy treatment 2x/week x 3 weeks is not medically necessary.

Right Elbow Extension Brace and Hellbow Support: 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) Elbow Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3 > Elbow (2013) > Cubital Tunnel > Table 2: Evaluation and Management

Decision rationale: The ACOEM V.3, Elbow (2013) recommends nocturnal elbow splinting or bracing for acute, subacute, or chronic ulnar neuropathies at the elbow as medically necessary. The requested treatment with a right elbow extension brace and Hellbow support fit into this category and are therefore medically necessary for the treatment of documented cubital tunnel syndrome in this patient with an abnormal ulnar nerve conduction study with mild interosseus muscle atrophy. The request is medically necessary.

Right Ulnar Nerve Decompression for the Right Elbow with Medical Epicondylectomy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 604.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3 > Elbow (2013) > Cubital Tunnel > Table 2: Evaluation and Management

Decision rationale: According to the ACOEM V.3 Guidelines for treatment of cubital tunnel syndrome, medial epicondylectomy for patients who fail non-operative treatment for subacute or chronic ulnar neuropathies is considered medically necessary as one of many surgical treatment options for treatment of cubital syndrome. The right ulnar nerve decompression is also an essential portion of the surgical procedure. The injured worker has physical findings of cubital tunnel syndrome including mild interosseus muscle atrophy as well as an abnormal ulnar nerve conduction velocity. Therefore, the requested treatment is medically necessary.