

Case Number:	CM14-0191289		
Date Assigned:	11/25/2014	Date of Injury:	09/26/2011
Decision Date:	01/12/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/17/2014

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 Occupational Medicine 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 applicant is a represented [REDACTED] employee who has filed a claim for bilateral elbow and neck pain reportedly associated with an industrial injury of September 26, 2011. The applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; electrodiagnostic testing of March 14, 2014, notable for bilateral median neuropathy; and 42 total sessions of physical and occupational therapy, per the claims administrator. In a Utilization Review Report dated November 4, 2014, the claims administrator denied a request for local corticosteroid injections for the bilateral elbows. A variety of MTUS and non-MTUS guidelines were invoked. The claims administrator stated that its denial was based on the fact that a comprehensive evaluation of the elbow was not performed on the most recent report dated September 17, 2014. The claims administrator, it is incidentally noted, did incongruously refer to the date of injury as September 17, 2014 in some instances and September 26, 2011 in some instances. The applicant's attorney subsequently appealed. In a May 29, 2014 progress note, the applicant reported persistent complaints of neck pain. The applicant was status post carpal tunnel release surgery in June 2013, it was noted. Cervical epidural steroid injection therapy was sought. The applicant was asked to discontinue Lyrica and employ Duexis, Soma, and tramadol. The applicant's work status was not furnished. On July 9, 2014, the applicant was placed off of work, on total temporary disability. The applicant was given diagnosis of cubital tunnel syndrome, left sided, on this occasion with bilateral tennis elbows. Tenderness was appreciated about the elbow epicondylar regions. Large portions of the progress note were difficult to follow, handwritten, not entirely legible. The applicant had been laid off by his former employer, it was further noted. On October 24, 2014, the applicant reported persistent complaints of shoulder pain and thoracic outlet syndrome. A shoulder corticosteroid injection was sought. The applicant was not currently working, it was

acknowledged, although the attending provider stated that he was not giving the applicant any formal limitations. On August 12, 2014, the applicant reported persistent complaints of neck and head pain status post greater and lesser occipital nerve blocks. The applicant exhibited some hyposensorium about the bilateral elbows, left greater than right, reportedly following the ulnar nerve distribution. It was stated that the applicant was in the process of consulting an elbow and shoulder surgeon to consider an ulnar nerve transposition surgery. The applicant had superimposed issues with myofascial pain syndrome, depression, and thoracic outlet syndrome, it was noted. Tramadol, Flexeril, and Duexis were sought. Cervical facet medial branch blocks were sought. In a handwritten note dated September 30, 2014, the attending provider posited that the applicant had paresthesias about the ring and small fingers, bilateral, right greater than left, attributed to early clinical cubital tunnel syndrome. Corticosteroid injection therapy for the bilateral elbows was sought while the applicant was kept off of work, on total temporary disability, for an additional eight weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cortisone Injections, Bilateral Elbows: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow, Injections (corticosteroid); and the Non-MTUS, <http://www.mdguidelines.com/neuropathy-of-ulner-nerve-entrapment>

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 19. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Third Edition, Elbow Chapter, Ulnar Neuropathies section

Decision rationale: While the California Medical Treatment Utilization Schedule (MTUS) does not specifically address the topic of elbow cortisone injections for ulnar nerve entrapment, the diagnosis reportedly present here, page 19 of the MTUS-adopted American College of Occupational and Environmental Medicine (ACOEM) Guidelines in Chapter 10 notes that treatment options which are recommended for ulnar nerve entrapment include elbow padding, avoiding leaning on the ulnar nerve at the elbow, avoiding prolonged hyperflexion at the elbow, and utilization of NSAIDs. Thus, cortisone injections for ulnar nerve entrapment are not explicitly recommended in the MTUS-adopted ACOEM Guidelines in Chapter 10. The Third Edition ACOEM Guidelines Elbow Chapter notes that there is "no recommendation" for or against usage of oral or injectable glucocorticosteroid injection therapy for the treatment of acute, subacute, or chronic ulnar neuropathies at the elbow. ACOEM, Third Edition further notes that injecting steroids into the cubital tunnel may in fact cause nerve damage. Here, it is noted that there is a considerable lack of diagnostic clarity present here. It is far from certain that the applicant carries a bona fide diagnosis of cubital tunnel syndrome. The applicant has been given several different and sometimes conflicting diagnoses, including cervical facet syndrome, cervical radiculopathy, occipital neuralgia, thoracic outlet syndrome, bilateral carpal tunnel syndrome, ulnar neuropathy, antecubital syndrome, etc. The request, thus, is not indicated both owing to the considerable lack of diagnostic clarity present here as well as owing to the tepid-to-

unfavorable ACOEM positions on the article at issue. Therefore, the request is not medically necessary.