

<b>Case Number:</b>	CM15-0147705		
<b>Date Assigned:</b>	08/10/2015	<b>Date of Injury:</b>	03/29/2013
<b>Decision Date:</b>	09/08/2015	<b>UR Denial Date:</b>	07/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 65-year-old female, who sustained an industrial injury on March 29, 2013. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. Prior peer review indicates the patient had a cervical spine injury on 3/29/13. The injured worker was diagnosed as having bilateral carpometacarpal arthritis and right extensor carpi ulnaris tendonitis. Treatment and diagnostic studies to date has included use bilateral carpometacarpal bracing, medication regimen, use of ice and heat, x-rays, status post right carpal tunnel release, ulnar nerve release, injection to the left carpometacarpal. The documentation provided did not indicate any prior therapy. In a progress note dated June 30, 2015 the treating physician reports complaints of burning pain to the right lateral elbow and the ulnar side of the wrist along with occasional numbness to the fifth digit. Examination reveals crepitus to the left carpometacarpal, weakness to the abductor pollicis brevis bilaterally, and tenderness to the extensor carpi ulnaris along with pain with resistance. The treating physician requested a custom extensor carpi ulnaris brace and therapy two times six sessions for worsening right extensor carpi ulnaris tendonitis with tenderness.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Custom ECU Brace:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264; 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic)-splints and Other Medical Treatment Guidelines British Journal of Sports Medicine Sports-related Extensor Carpi Ulnaris Pathology A Review of Functional Anatomy, Sports Injury and Management Doug Campbell; Rob Campbell; Phil O'Connor; Roger Hawkes Disclosures Br J Sports Med. 2013;47(17):1105-1111.

**Decision rationale:** Custom ECU brace is not medically necessary per the MTUS and the ODG Guidelines. The ODG recommends splinting for non-displaced fractures. The MTUS recommends splinting for carpal tunnel syndrome. The MTUS states that there is limited (C) evidence that splinting can be used for carpal tunnel syndrome, deQuervain's and acute strains but that prolonged splinting is not recommended. A review of this condition online reveals that in stable ECU tendinopathy, it is more usual to describe an 'area' of discomfort or ache, rather than a specific and accurately described 'point' of pain. The documentation does not reveal evidence of an acute ECU injury, which can be treated with splinting. The documentation describes symptoms that are more chronic and less specific and the guidelines do not support splinting in chronic conditions or for prolonged periods. Furthermore, a review of this condition reveals that other causes of ulnar-sided wrist pain must be considered. The documentation indicates that the patient has a history of cervical pathology and has had radiating symptoms down her arms and numbness in her fifth digit. The documentation is not clear that other causes of ulnar-sided wrist pain such as referred cervical pain were considered. The documentation does not reveal evidence that the splint is being used for one of the above conditions recommended by the MTUS or ODG. The documentation is not clear on length of use of this splint, as the guidelines do not support prolonged splinting. The request for this splint is not medically necessary.

**Therapy 2x6 visits:** 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:** Therapy 2x6 visits is not medically necessary per the MTUS Guidelines. The MTUS recommends up to 10 visits for neuritis and up to 10 visits for myalgia/myositis with transition of therapy to an independent home exercise program. The request exceeds the recommended 10 visits of therapy for this patient's condition. The request does not specify a body part and is therefore not medically necessary.

