MAXIMUS Federal Services

Case Number:	CM15-0020109		
Date Assigned:	02/09/2015	Date of Injury:	10/01/2010
Decision Date:	04/01/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	02/03/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 40 year old female, who sustained an industrial injury on October 1, 2010. The injured worker has reported bilateral elbow, wrist and hand pain. The diagnoses have included ulnar neuritis on the right, medical and lateral epicondylitis on the right, bilateral wrist joint inflammation and chronic pain syndrome. Treatment to date has included pain medication, x-rays of the elbow, MRI of the right wrist, a transcutaneous electrical nerve stimulation unit, electrodiagnostic testing, a right carpel tunnel release in 2011 and an extensor tenosynovectomy on the right in 2011. Current documentation dated December 9, 2014 notes that the injured worker reported right wrist, hand and elbow pain, as well as persistent pain, swelling, numbness and tingling of the left hand. Physical examination revealed tenderness along both wrists, carpometacarpal joint, first extensor and pain along the dorsum of both wrists. On December 30, 2014 Utilization Review non-certified requests for hand therapy or occupational therapy services time's twelve, an elbow brace, a urine drug screen and a hinged elbow brace. The MTUS, Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines, were cited. On February 3, 2015, the injured worker submitted an application for IMR for review of hand therapy or occupational therapy services time's twelve, an elbow brace, a urine drug screen and a hinged elbow brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hand therapy or occupational therapy; 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

Decision rationale: The patient presents with bilateral elbow and wrist pain. The request is for HAND THERAPY OR OCCUPATIONAL THERAPY, 12 SESSIONS. Patient is status post right carpel tunnel release December 2011 and right extensor tenosynovectomy May 2011. Physical examination on 10/06/14 to bilateral wrists revealed tenderness to palpation along the carpal tunnel area radiating to the wrist. Patient's treatments have included medication, x-rays of the elbow, MRI of the right wrist, a transcutaneous electrical nerve stimulation unit, electrodiagnostic testing and a TENS unit. Per 12/09/14 progress report, patient's diagnosis include ulnar neuritis on the right, medial and lateral epicondylitis on the right, although not to stretch or resisted function, wrist joint inflammation, status post arthrotomy and synovectomy on the right wrist, extensor tenosynovectomy, extensor tenosynovectomy along the fourth, fifth and sixth extensor compartment, arthrotomy of the wrist, debridement of the TFCC and chondroplasty along carpal bones (the bones are not described at the surgical note) done in May 2011 as well as carpal tunnel release in December 2011with persistent symptomalogy, left wrist inflammation with CMC joint inflammation, STT joint inflammation, the left wrist now being covered by qualified examiner, and chronic pain syndrome. Per 12/09/14 progress report, patient’s medications include Norco, Tramadol, Naflon, Gabapentin and Lunesta. Patient is currently not working. MTUS pages 98 and 99 have the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Patient is not within post operative time period, as right carpel tunnel release and right extensor tenosynovectomy were performed in 2011. A short course of physical therapy would be indicated by guidelines given patient's symptoms, however there is no documentation of treatment history. Furthermore, treater has not discussed why patient cannot move on to home exercise program. In addition, the requested 12 sessions exceeds what is allowed per MTUS for this type of condition. Therefore, the request IS NOT medically necessary.

Elbow pad: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Elbow (Acute & Chronic) chapter, Splinting.

Decision rationale: The patient presents with bilateral elbow and wrist pain. The request is for HAND THERAPY OR OCCUPATIONAL THERAPY, 12 SESSIONS. Patient is status post right carpel tunnel release December 2011 and right extensor tenosynovectomy May 2011. Physical examination on 10/06/14 to bilateral wrists revealed tenderness to palpation along the carpal tunnel area radiating to the wrist. Patient's treatments have included medication, x-rays of the elbow, MRI of the right wrist, a transcutaneous electrical nerve stimulation unit, electrodiagnostic testing and a TENS unit. Per 12/09/14 progress report, patient's diagnosis include ulnar neuritis on the right, medial and lateral epicondylitis on the right, although not to stretch or resisted function, wrist joint inflammation, status post arthrotomy and synovectomy on the right wrist, extensor tenosynovectomy, extensor tenosynovectomy along the fourth, fifth and sixth extensor compartment, arthrotomy of the wrist, debridement of the TFCC and chondroplasty along carpal bones (the bones are not described at the surgical note) done in May 2011 as well as carpal tunnel release in December 2011 with persistent symptomalogy, left wrist inflammation with CMC joint inflammation, STT joint inflammation, the left wrist now being covered by qualified examiner, and chronic pain syndrome. Per 12/09/14 progress report, patient's medications include Norco, Tramadol, Naflon, Gabapentin and Lunesta. Patient is currently not working. ODG Guidelines, Elbow (Acute & Chronic) chapter, under Splinting states the following: "Recommended for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces). (Apfel, 2006) (Hong, 1996) Under study for epicondylitis. No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis. (Borkholder, 2004) (Derebery, 2005) (Van De Streek, 2004) (Jensen, 2001) (Struijs, 2001) (Jansen, 1997) If used, bracing or splitting is recommended only as short-term initial treatment for lateral epicondylitis in combination with physical therapy. (Struijs, 2004) (Struijs, 2006) Some positive results have been seen with the development of a new dynamic extensor brace but more trials need to be conducted. Initial results show significant pain reduction, improved functionality of the arm, and improvement in pain-free grip strength. The beneficial effects of the dynamic extensor brace observed after 12 weeks were significantly different from the treatment group that received no brace. The beneficial effects were sustained for another 12 weeks. (Faes, 2006) (Faes2, 2006) Static progressive splinting can help gain additional motion when standard exercises seem stagnant or inadequate, particularly after the original injury. Operative treatment of stiffness was avoided in most patients. (Doornberg, 2006) These results differ from studies testing standard bracing which showed little to no effect on pain." Treater does not provide a reason for the request. In this case, the patient is diagnosed with ulnar neuritis on the right, per 12/09/14 progress report. The ODG guidelines recommend elbow padding for cubital tunnel syndrome (ulnar nerve entrapment) to limit movement and reduce irritation. The request for elbow pad is within ODG Guidelines. Therefore, the request IS medically necessary.

Urine drug screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Urine drug testing.

Decision rationale: The patient presents with bilateral elbow and wrist pain. The request is for URINE DRUG TEST. Patient is status post right carpel tunnel release December 2011 and right extensor tenosynovectomy May 2011. Physical examination on 10/06/14 to bilateral wrists revealed tenderness to palpation along the carpal tunnel area radiating to the wrist. Patient's treatments have included medication, x-rays of the elbow, MRI of the right wrist, a transcutaneous electrical nerve stimulation unit, electrodiagnostic testing and a TENS unit. Per 12/09/14 progress report, patient's diagnosis include ulnar neuritis on the right, medial and lateral epicondylitis on the right, although not to stretch or resisted function, wrist joint inflammation, status post arthrotomy and synovectomy on the right wrist, extensor tenosynovectomy, extensor tenosynovectomy along the fourth, fifth and sixth extensor compartment, arthrotomy of the wrist, debridement of the TFCC and chondroplasty along carpal bones (the bones are not described at the surgical note) done in May 2011 as well as carpal tunnel release in December 2011with persistent symptomalogy, left wrist inflammation with CMC joint inflammation, STT joint inflammation, the left wrist now being covered by qualified examiner, and chronic pain syndrome. Per 12/09/14 progress report, patient’s medications include Norco, Tramadol, Naflon, Gabapentin and Lunesta. Patient is currently not working. MTUS Chronic Pain Medical Treatment Guidelines, for Testing, pg 43 states: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. ODG-TWC Guidelines, online, Pain chapter for Urine Drug Testing states: Patients at 'low risk' of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. In this case, patient has been prescribed Norco and Tramadol from 06/10/14 and 12/09/14. There are no records of a prior UDS. ODG states that once yearly screening is sufficient for "chronic opiate use in low risk patient." The request appears to be reasonable and is within the guideline recommendations and therefore, it IS medically necessary.

Hinged elbow brace: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Elbow (Acute & Chronic) chapter, under Splinting.

Decision rationale: The patient presents with bilateral elbow and wrist pain. The request is for HINGED ELBOW BRACE. Patient is status post right carpel tunnel release December 2011 and right extensor tenosynovectomy May 2011. Physical examination on 10/06/14 to bilateral wrists revealed tenderness to palpation along the carpal tunnel area radiating to the wrist. Patient's treatments have included medication, x-rays of the elbow, MRI of the right wrist, a transcutaneous electrical nerve stimulation unit, electrodiagnostic testing and a TENS unit. Per

12/09/14 progress report, patient's diagnosis include ulnar neuritis on the right, medial and lateral epicondylitis on the right, although not to stretch or resisted function, wrist joint inflammation, status post arthrotomy and synovectomy on the right wrist, extensor tenosynovectomy, extensor tenosynovectomy along the fourth, fifth and sixth extensor compartment, arthrotomy of the wrist, debridement of the TFCC and chondroplasty along carpal bones (the bones are not described at the surgical note) done in May 2011 as well as carpal tunnel release in December 2011with persistent symptomalogy, left wrist inflammation with CMC joint inflammation, STT joint inflammation, the left wrist now being covered by qualified examiner, and chronic pain syndrome. Per 12/09/14 progress report, patient’s medications include Norco, Tramadol, Naflon, Gabapentin and Lunesta. Patient is currently not working. ODG Guidelines, Elbow (Acute & Chronic) chapter, under Splinting states the following: "Recommended for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces). (Apfel, 2006) (Hong, 1996) Under study for epicondylitis. No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis. (Borkholder, 2004) (Derebery, 2005) (Van De Streek, 2004) (Jensen, 2001) (Struijs, 2001) (Jansen, 1997) If used, bracing or splitting is recommended only as short-term initial treatment for lateral epicondylitis in combination with physical therapy. (Struijs, 2004) (Struijs, 2006) Some positive results have been seen with the development of a new dynamic extensor brace but more trials need to be conducted. Initial results show significant pain reduction, improved functionality of the arm, and improvement in pain-free grip strength. The beneficial effects of the dynamic extensor brace observed after 12 weeks were significantly different from the treatment group that received no brace. The beneficial effects were sustained for another 12 weeks. (Faes, 2006) (Faes2, 2006) Static progressive splinting can help gain additional motion when standard exercises seem stagnant or inadequate, particularly after the original injury. Operative treatment of stiffness was avoided in most patients. (Doornberg, 2006) These results differ from studies testing standard bracing which showed little to no effect on pain." Treater had not provided a reason for the request. Based on the 12/09/14 progress report, patient's diagnosis includes ulnar neuritis on the right. In this case, the requested elbow pad would be reasonable but not a hinged elbow brace. ODG guidelines support either a foam pad or splinting at night time to treat ulnar neuropathy. There is no support or discussion regarding hinged elbow brace. The request IS NOT medically necessary.