

<b>Case Number:</b>	CM14-0132918		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	05/28/2013
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2014

### 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 Family 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:

This 45-year old packer reported injuries to both hands, wrists, forearms and elbows due to repetitive motion at work, date of injury 5/28/13. Treatment has included ibuprofen, topical creams, physical therapy, and wrist supports. An orthopedist evaluated her on 7/26/13. His report documents tenderness of both elbows at the lateral epicondyles. The hand and wrist exam was completely normal, including strength, sensation and range of motion of all joints. Tests for carpal tunnel syndrome were negative. He diagnosed bilateral elbow and wrist tendonitis, and recommended ongoing physical therapy. There are three lengthy reports in the records from the current primary treater's office dated 2/5/14, 3/19/14 and 4/23/14. An initial disclaimer in each makes it unclear whether the exams were performed by the primary treater (an orthopedist) or by a physicians' assistant. Each documents ongoing symptoms of pain in both elbows and wrists, with severe (10/10) elbow pain. Exam findings include nonspecific tenderness of the elbows and wrists, decreased sensation bilaterally of the medial forearm, hand, and ring and little fingers, and positive Tinel's signs at the elbow and both wrists. Strength is documented as normal, though every exam includes Jamar strength testing which is abnormally low. Diagnoses include bilateral elbow lateral epicondylitis, bilateral ulnar nerve injury (cubital tunnel syndrome) and depression. The patient's status is listed as temporarily totally disabled for all three visits. All three plans included a prescription of bilateral Pil-O-splints. A rationale is recorded twice: on 2/5/14 as "LE Pil-O-splints for prophylactic purposes to avoid exacerbation of the current injury". (LE is an abbreviation for lower extremity.), and on 3/19/14 as for "support and stability. The records contain a custody control form for a urine drug screen performed 5/28/14, with indicated reason for the test as "Post Accident". The signature of the collector is a hand-drawn happy face, which would indicate that the collection was not taken seriously, and perhaps not performed correctly. The 5/28/13 progress note, signed by a PA, lists the patient's

medications as including ibuprofen only. It notes that a UDS was done that day, but gives no rationale for ordering it. There is a lengthy rationale on the urine toxicology review form, quoting MTUS and stating that the test was done to monitor compliance with the pharmacological regime and to identify possible drug interactions. The test results are negative for 12 drugs; Ibuprofen was not tested. Per the UR report dated 8/18/14, the most recent progress note is that of 7/23/14. This note apparently included requests for bilateral Pil-O-splints and a urine drug screen, but it is not among the notes available to me.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Pil-O-splints, bilateral upper extremities number two (2): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation , (2004) Elbow complaints, pages 18, 26 and 45

**Decision rationale:** A Pil-O splint is used during sleep to maintain a desired position of a particular joint. There are Pil-O splints available for both wrists and elbows. Although it is not entirely clear, this request appears to be for bilateral elbow splints, since there is one recent (4/14/14) request for authorization for bilateral elbow braces in the available records. Elbow Pil-O splints maintain the elbows in extension. It is not feasible to wear them during the day, since they make it impossible to use the hands for activities such as eating and driving. The MTUS guidelines cited above support the use of tennis elbow bands or braces, or epicondylitis straps for the treatment of epicondylitis. They also support the use of daytime padding and nocturnal splinting of the elbow for ulnar neuropathy. The rationales documented by the provider for these splints is that they are requested for "prophylactic purposes to avoid exacerbation of the current injury" and "support an stability". Both of these rationales may imply day use of these splints. It is unclear which of this patient's elbow conditions they are being used to treat. Pil-O splints are not indicated to treat lateral epicondylitis, and padding rather than splints would be more appropriate for daytime treatment of ulnar neuropathy. Based on the evidence-based references above and the clinical findings in the case, Pil-O-splints, bilateral upper extremities, #2 are not medically necessary. They are not medically necessary because the treating physician has not provided sufficient information about when they will be used and what condition(s) they are being used for.

**Urine drug screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines, Opioids, Criteria for Use, Therapeutic Trial of Opioids Opioids, Ongoing

Management. Decision based on Non-MTUS Citation ODG), Pain Section, Urine Drug Testing, criteria for use

**Decision rationale:** Per the MTUS guidelines cited above, an assessment of the likelihood for substance abuse should be made before a therapeutic trial of opioid use is begun. The section on ongoing management of opioid use recommends that regular assessment for aberrant drug taking behavior should be performed. Drug screens should be used in patients with issues of abuse, addiction or poor pain control. The section on steps to avoid misuse/addiction recommends frequent random urine toxicology screens. Per the ODG reference cited, clinicians should be clear on the indication for using a UDS prior to ordering one. Testing frequency should be determined by assessing the patient's risk for misuse, with low-risk patients to receive random testing no more than twice per year. Documentation of the reasoning for testing frequency, need for confirmatory testing, and of risk assessment is particularly important in stable patients with no evidence of risk factors or previous aberrant drug behavior. Standard drug classes should be included in the testing, including cocaine, amphetamines, opiates, oxycodone, methadone, marijuana, and benzodiazepines. Others may be tested as indicated. A complete list of all drugs the patient is taking, including OTC and herbal preparations must be included in the request accompanying the test, as well as documentation of the last time of use of specific drugs evaluated for. Random collection is preferred. Unexpected results (illicit drugs, scheduled drugs that were not prescribed, or negative results for a prescribed drug) should be verified with [REDACTED]. The clinical findings in this case do not support the use of a urine drug screen. This patient is not taking an opioid--the only drugs documented for her treatment include ibuprofen and topical creams. None of the records contain any documentation of a concern that she may at risk for illicit drug use or aberrant behavior. In fact there is no documentation of any risk assessment for this patient, or of any reason for ordering drug testing that applies to her specifically. Based on the evidence-based guidelines cited above and the clinical findings in this case, a urine drug screen is not medically necessary. It is not medically necessary because this patient is not taking opioids, because there is no documentation of any risk for aberrant drug behavior, or of any other reason for obtaining a urine drug screen in this case.