

<b>Case Number:</b>	CM14-0206910		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	10/15/2012
<b>Decision Date:</b>	02/12/2015	<b>UR Denial Date:</b>	11/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2014

### 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 Physical Medicine Rehab, has a subspecialty in Interventional Spine 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 patient is a 49-year-old male with a date of injury of 10/15/2012. According to progress report dated 11/10/2014, the patient is status post right lateral epicondylitis debridement and repair surgery performed on 10/02/2013. The patient reports that the right elbow is doing well since surgery and he has less pain and improved range of motion and strength. The patient reports a recent flare-up of the left elbow (ulnar neuritis). He reports increasing frequency of numbness and tingling and burning in the medial left elbow and radiates to the left hand digits 4 and 5. The patient has tried home exercises, icing, antiinflammatories, and elbow padding with minimal relief. The patient has recently returned to full duty. Examination revealed +TTP flexor medial origin, and pain with resisted wrist flexion in the left elbow. There is minimal tenderness over the extensor origin. Positive flexion test and positive Tinel's in the left elbow were noted. Wrist range of motion is mildly restricted. The listed diagnoses are: 1. Lesion of ulnar nerve. 2. Lateral epicondylitis. Treatment plan is for 6 acupuncture sessions, 8 hand therapy sessions, medications, splint for the elbow to be utilized at night, and "custom-made elbow pad to be made during the day." The Utilization review denied the request on 11/13/2014. Medical file provided for review includes treatment reports from 04/04/2014 through 11/10/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Elbow pad for the left elbow:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines treatment in Workers' Compensation, Online Edition Chapter: Elbow (Acute & Chronic), Splinting (padding)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) elbow chapter has the following regarding splinting (padding).

**Decision rationale:** This patient is status post right lateral epicondylitis debridement and repair surgery performed on 10/02/2013. The patient reports a flare-up of increasing frequency of numbness, tingling, and burning in the medial left elbow that radiates into the left hand in digits 4 and 5. The current request is for elbow pad for the left elbow. Utilization review denied the request stating that "it was noted that the patient had previously used elbow padding with minimal relief, with no indication that the elbow pad has worn out." The ODG Guidelines under the elbow chapter has the following regarding splinting (padding), "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 prevent against chronic irritation from hard surfaces." In this case, the treating physician has noted that the patient has a flare-up of left tennis elbow and ulnar neuritis. The ODG guidelines recommend elbow padding for cubital tunnel syndrome (ulnar nerve entrapment) to limit movement and reduce irritation. The treating physician's request for elbow pad is within ODG Guidelines and the request IS medically necessary.