MAXIMUS Federal Services

Case Number:	CM14-0215319		
Date Assigned:	01/02/2015	Date of Injury:	02/27/2012
Decision Date:	02/28/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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: New Jersey, Michigan, California
Certification(s)/Specialty: Neurology, 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 patient is a 54-year-old man who sustained a work-related injury on February 27, 2012. Subsequently, he developed low back pain. Prior treatments included: left CTR, medications, and physical therapy. MRI of the lumbar spine dated April 18, 2012 showed mild to moderate shortening of all pedicles causing a decreased resevre of the central canal and neural foramina. Mild to moderate circumferential disc bulge and posterior element hypertrophic changes at L2-3, L3-4, L4-5, and L5-S1 with mild central canal stenosis at L2-3 and bilateral lateral recess stenosis at L2-3, L3-4, L4-5, and L5-S1. According to a progress report dated December 22, 2014, the patient reported bilateral heel pain in the mornings He had morning back stiffness. He had pain with standing or walking for more than 20-30 minutes. This pain referred from the lower back to the thighs and calves bilaterally. The patient rated his pain level as a 9/10 without medication and 7/10 with medications. The patient was diagnosed with lumbar spondylosis without myelopathy, carpal tunnel syndrome, and cubital tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Epidural Steroid Injection, L4-5 Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit, however there is no signficant long term benefit or reduction for the need of surgery. There is no clear evidence from the physical examination of radiculopathy. There is no EMG study documenting radiculopathy. MTUS guidelines does not recommend epidural injections for back pain without radiculopathy.

Elbow Braces Qty: 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Splinting.

Decision rationale: According to ODG guidelines, elbow brace is 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. (Wuori, 1998) (AHRQ, 2002) (Gabel, 1999) See also Static progressive stretch therapy and Tennis elbow band. There is no clear evidence of cubital tunnel syndrome or any indication for an elbow brace. Therefore, the request is not medically necessary.