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| <b>Case Number:</b>   | CM15-0043586 |                              |            |
| <b>Date Assigned:</b> | 03/13/2015   | <b>Date of Injury:</b>       | 01/22/2013 |
| <b>Decision Date:</b> | 05/14/2015   | <b>UR Denial Date:</b>       | 02/09/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/09/2015 |

### 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 51 year old female, who sustained an industrial injury on 01/22/2013. She reported injuries to the back, neck, bilateral shoulder, bilateral elbows and wrists and both hands as a result of work duties. Diagnoses include cervical discogenic pain, cervical radiculopathy and carpal tunnel syndrome, status post right side carpal tunnel release 6/21/13. She has a history of a left wrist dislocation in 1992 with surgery and pins, with pins removed, unrelated to the reported injury. Treatments to date include medication therapy and post-surgical physical therapy. Currently, they complained of cervical spine pain and thoracic pain with radiation to lower extremities associated with numbness, tingling and weakness. On 1/5/15, the physical examination documented decreased cervical range of motion with tenderness to palpation. The plan of care included continuation of medication therapy while pending authorization for MRI of bilateral elbow, electromyogram (EMG) of bilateral upper extremities, bilateral forearm braces and right thumb brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the bilateral elbows:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Elbow Chapter, MRIs.

**Decision rationale:** Based on the 12/16/14 progress report provided by treating physician, the patient presents with pain to neck and right upper extremity pain and sensitivity. The request is for MRI of the Bilateral Elbows. The patient is status post right carpal tunnel release, June 2013. Patient's diagnosis per Request for Authorization form dated 02/03/15 includes status post right CTR. Diagnosis on 12/16/14 included right upper extremity complex regional pain syndrome, and multilevel cervical degenerative disc disease with stenosis and myofascial dysfunction. Medications per 08/26/14 treater report included Cymbalta, Elavil, Lyrica and Lidoderm patches. The patient is temporarily totally disabled, per treater report dated 12/16/14. ODG Guidelines, Elbow Chapter, under MRIs state: "Recommended as indicated below: Magnetic resonance imaging may provide important diagnostic information for evaluating the adult elbow in many different conditions, including: collateral ligament injury, epicondylitis, injury to the biceps and triceps tendons, abnormality of the ulnar, radial, or median nerve, and for masses about the elbow joint. There is a lack of studies showing the sensitivity and specificity of MR in many of these entities; most of the studies demonstrate MR findings in patients either known or highly likely to have a specific condition. Epicondylitis (lateral "tennis elbow" or medial in pitchers, golfers, and tennis players) is a common clinical diagnosis, and MRI is usually not necessary. Magnetic resonance may be useful for confirmation of the diagnosis in refractory cases and to exclude associated tendon and ligament tear." (ACR, 2001) See also ACR Appropriateness Criteria Treater has not provided reason for the request. Physical examination on 12/16/14 revealed hyperalgia, allodynia to pinwheel, and moderate weakness to right upper extremity. Right Jamar 0 and left 10. Limited and painful cervical range of motion, and positive axial head compression test. There is no record of prior MRI to the elbows. ODG allows MRI for different symptoms of the elbow. In this case, given the patient's continued pain, an MRI for further diagnostic evaluation of the right elbow would be indicated. However, there are no discussions or remarkable findings pertaining to the left elbow, to warrant imaging studies of both elbows. Therefore, the request is not medically necessary.

**DME of the bilateral forearm braces:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 20, 265. Decision based on Non-MTUS Citation Official disability guidelines Elbow chapter, splinting Pain (Chronic) Chapter, CRPS.

**Decision rationale:** Based on the 12/16/14 progress report provided by treating physician, the patient presents with pain to neck and right upper extremity pain and sensitivity. The request is for DME of the Bilateral Forearm Braces. The patient is status post right carpal tunnel release,

June 2013. Patient's diagnosis per Request for Authorization form dated 02/03/15 includes status post right CTR. Diagnosis on 12/16/14 included right upper extremity complex regional pain syndrome, and multilevel cervical degenerative disc disease with stenosis and myofascial dysfunction. Physical examination on 12/16/14 revealed hyperalagia, allodynia to pinwheel, and moderate weakness to right upper extremity. Right Jamar 0 and left 10. Limited and painful cervical range of motion, and positive axial head compression test. Medications per 08/26/14 treater report included Cymbalta, Elavil, Lyrica and Lidoderm patches. The patient is temporarily totally disabled, per treater report dated 12/16/14. ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10, page 20 states regarding epicondylar pain: "If the treatment response is inadequate, such that symptoms and activity limitations continue, prescribed pharmaceuticals, orthotics, or physical methods can be added. Conservative care often consists of activity modification using epicondylar supports (tennis elbow bands), and NSAIDs with standard precautions on potential side effects." ODG guidelines Elbow chapter under splinting: "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." ACOEM Guidelines, Chapter 11, page 265 states, "When treating with splints and CTS, scientific evidence supports the efficacy of neutral wrist splints. Splinting would be used at night and may be used during the day depending upon activity." ODG-TWC, Pain (Chronic) Chapter, under CRPS, treatment states: "Recommend hierarchy of options as indicated below. The goal is to improve function. There are no evidence-based treatment guidelines, but several groups have begun to organize treatment algorithms that are consensus based. There is currently no intervention for CRPS that can be considered to be supported by strong evidence of efficacy. (Ribbers, 2003)" Treater has not provided reason for the request. In this case, the patient is status post right carpal tunnel release 2013 and splinting the right wrist would be supported by guidelines. However, it appears treater is requesting braces for the management of this patient's forearm pain. ACOEM supports orthotics for epicondylar pain, and ODG recommends such conservative interventions for chronic elbow pain, for the diagnosis of cubital tunnel syndrome, which have not been documented. This patient presents with symptoms and diagnosis of CRPS, for which bracing is not indicated by guidelines. ODG further states "currently no intervention for CRPS that can be considered to be supported by strong evidence of efficacy." Additionally, the request is for bilateral braces, and there is no documentation of symptoms or findings that are remarkable for the left upper extremity. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.