

<b>Case Number:</b>	CM15-0073872		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	01/17/2012
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 male, who sustained an industrial injury on 1/17/2012. The injured worker was diagnosed as having carpal tunnel syndrome, status post left carpal tunnel release and left cubital tunnel release in 2012, and sprains and strains of unspecified site of elbow and forearm. Treatment to date has included diagnostics, surgical interventions, physical therapy, and medications. Currently, the injured worker complains of rectal bleeding. The treatment plan included new bilateral elbow and wrist supports, due to his being worn. Medication regime included start Tylenol #3, Colace, and discontinue Tramadol. A prior progress report documented bilateral arm pain. He rated pain at 8/10 with activity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral elbow support (purchase): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow (Acute & Chronic).

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

**Decision rationale:** The ACOEM chapter on elbow pain states: Epicondylalgia Supports (Tennis Elbow Bands, Braces or Epicondylitis Straps): Eleven articles were reviewed on orthotics for epicondylalgia, five studies 52, 53, 54, 55, 56 and six meta-analyses. 57, 58, 59, 60, 61, 62. Three of the studies were of intermediate quality and two were of low quality. One study examined a sample of 63 patients with symptoms for 6 weeks or longer in which 30 received treatment with the dynamic extensor brace and 33 received no brace for 12 weeks (there was a crossover period from weeks 12-24, where the no brace group received treatment with the brace) 53. The results of the study showed that "12 weeks of brace treatment results in relief of pain, improvement in functionality of the arm, and pain-free grip strength in patients with lateral epicondylitis. The beneficial effects last for at least another 12 weeks after cessation of the brace therapy." Another study evaluated 180 patients (with symptoms for at least 6 weeks) treating them with either physical therapy (n = 56), an Epipoint brace (n = 68) or combination of physical therapy and brace treatment (n = 56) 54. As the physical therapy regimen was not specified, the results are un-interpretable. The authors concluded that "brace treatment might be useful as initial therapy. Combination therapy has no additional advantage compared to physical therapy but is superior to brace only for the short term [6 weeks]." Quality studies are available on epicondylalgia supports in acute, subacute, and chronic lateral epicondylalgia patients, although the braces most commonly used in research studies are not widely used in the US. There is evidence of benefits. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence to support their use, they are recommended [Insufficient Evidence (I), Recommended]. The patient does not have the diagnosis of primary epicondyle disease and therefore bracing/splinting would not be indicated. The request IS NOT medically necessary.

**Bilateral wrist support (purchase):** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

**Decision rationale:** The ACOEM chapter on wrist complaints and splinting states: Initial treatment of CTS should include night splints. Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. For patients with mild-to-moderate CTS who opt for conservative treatment, studies show that corticosteroids may be of greater benefit than non-steroidal anti-inflammatory drugs (NSAIDs), but side effects prevent their general recommendation. The patient does have the diagnosis of carpal tunnel syndrome. The ACOEM does recommend splinting for this and therefore the request is certified. The request IS medically necessary.

